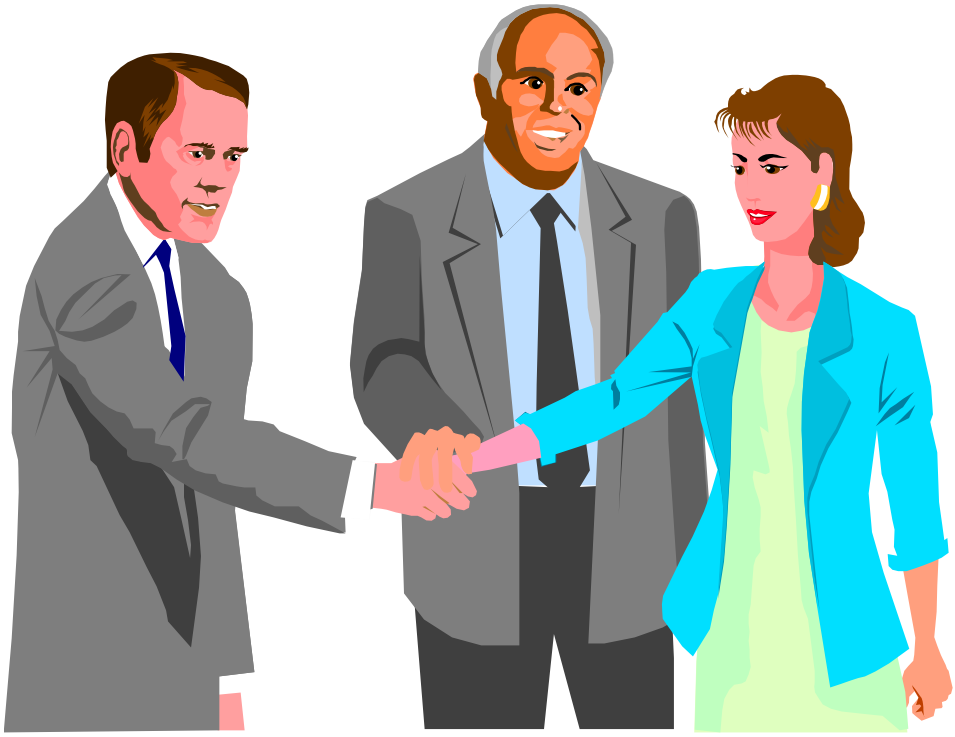
RESOURCE DIRECTORY

January, 2005

DEPARTMENT FOR MEDICAID SERVICES

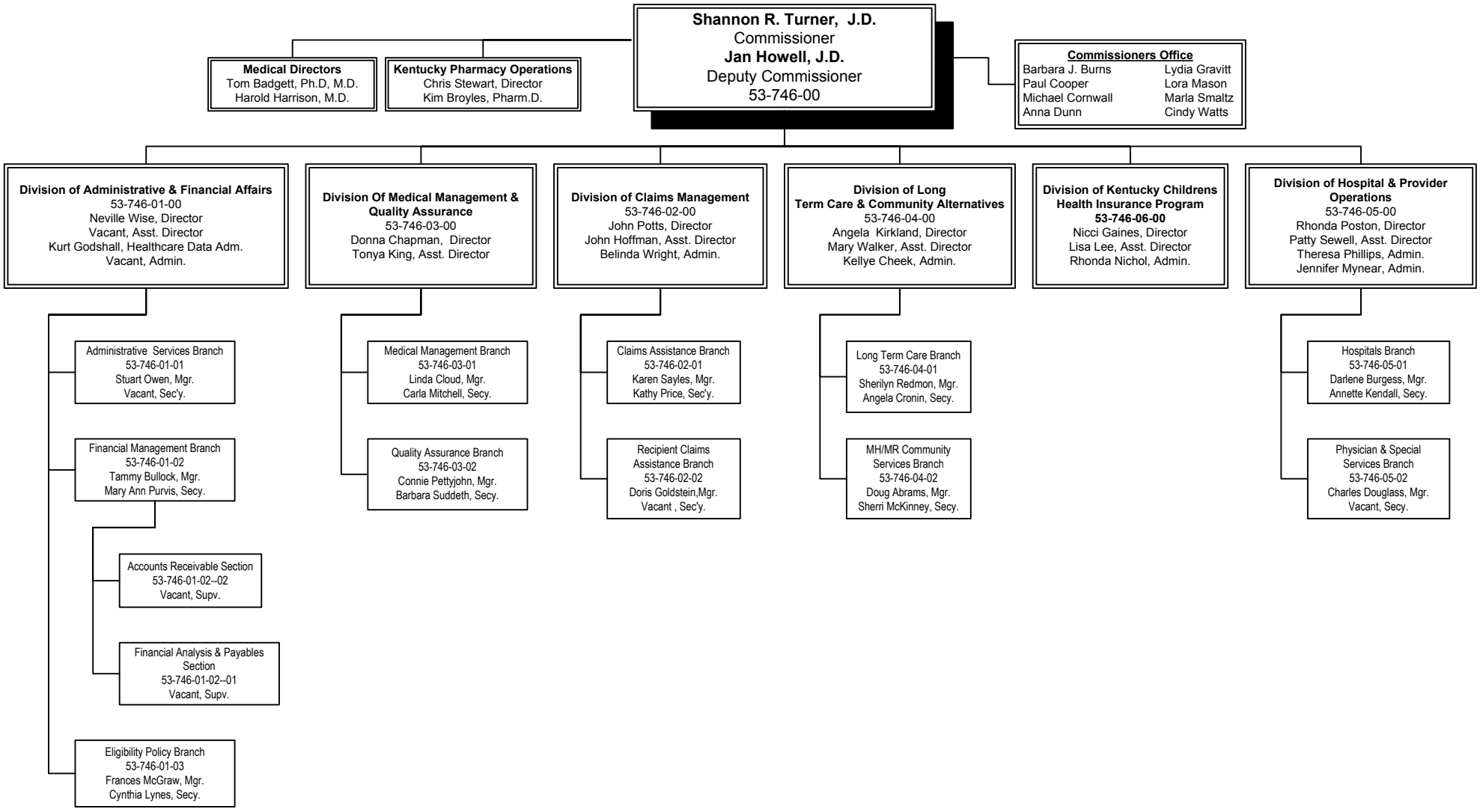
CHR Building, 6W-A
275 East Main Street
Frankfort, Kentucky 40621



Shannon Turner, Commissioner

Phone: (502) 564-4321
FAX (502) 564-0509

Department for Medicaid Services



Effective 9/16/05

Department for Medicaid Services

Table of Contents:

Appendices:

Department for Medicaid Services

(Mail Stop 6W-A)

The Cabinet for Health Services is the primary agency in state government responsible for the development and operation of health programs, including all federal programs in which the Commonwealth elects to participate. The Secretary of the Cabinet is the chief executive and administrative officer of the Cabinet for Health Services. The Secretary of the Cabinet for Health Services has delegated to the Department for Medicaid Services, line organizational responsibilities as the medical assistance unit within the government of the Commonwealth of Kentucky. The Department for Medicaid Services is the single state agency in the Commonwealth to administer Title XIX and Title XXI of the Social Security Act of 1935, as amended under the direction of the Secretary of the Cabinet for Health Services.

The Department for Medicaid Services is directly concerned with administration of all aspects of the Kentucky Medicaid Program and with attaining its objectives. It is responsible for promoting and administering the provision of a continuum of high quality comprehensive services to indigent citizens of the Commonwealth of Kentucky so as to improve their health care. There is a further responsibility for the Department to promote efficiency in assuring the availability and accessibility of facilities and resources, particularly in rural and urban poverty areas where shortages of health resources prevail. To be effective in these respects, it is essential for the Department to have a unified philosophy, clearly defined goals, and sufficient authority to carry out its responsibilities. As the organizational unit administering the Medicaid program, the Department is responsible for developing, recommending, and implementing policies, standards, and procedures relating to benefit elements. The functions and responsibilities of the Department include, but are not limited to, the following:

- Certifying the need of recipients for Medical Assistance and issuing authorizations for provision of Medical Assistance;
- Certifying the provision of medical care in accordance with quality and quantity standards as established;
- Developing bases and methods of payment for the medical services provided and certifying vendor billings for compliance with established base of payments;
- Developing and implementing a managed care program for the delivery of physical and behavioral health services through Health Care Partnerships and KenPAC;
- Redirecting the emphasis of services through managed care toward primary care and prevention while improving accessibility, availability and quality of care; and
- Developing and implementing a capitated non-emergency medical transportation delivery system, excluding emergency/ambulance stretcher services.

In the course of carrying out the above specifically designated functions and in providing staff assistance to the Advisory Council for Medical Assistance, the Department for Medicaid Services performs other functions, including but not limited to:

- Developing, implementing, and disseminating policy and procedure material relevant to service benefits;
- Preparing and managing the Program budget;
- Conducting research analysis and evaluation, and preparing special reports on the findings thereof;

- Conducting provider and recipient utilization review for use as a control technique in the enforcement of quality and quantity standards;
- Establishing and maintaining a data base for the generation of statistics necessary for the operation and management of the program;
- Maintaining a complete system of claims processing;
- Determining recipient qualifications for specific service benefits;
- Verifying recipient eligibility and certifying provider payments;
- Providing oversight of the managed care program for the delivery of physical and behavioral health services;
- Providing oversight of the capitated non-emergency medical transportation delivery system; and
- Administering a quality improvement program to monitor and evaluate the health and health outcomes of members.

The organizational structure of the Department consists of a commissioner, deputy commissioner, Chief Medical Officer and six (6) divisions. Each division is comprised of management, professional, and clerical staff who specialize in specific program areas. Each division director assumes specific responsibility in one of the six (6) following divisions:

- Division of Children's Health Insurance (KCHIP);
- Division of Long Term Care & Community Alternatives;
- Division of Medical Management & Quality Assurance;
- Division of Administration & Financial Management;
- Division of Claims Management;
- Division of Hospitals & Provider Operations.

Division of Administration and Financial Management

(502) 564-8196

Mail Stop 6W-C

This division is responsible for the Department's policy, financial analysis and has the responsibility for formulation and monitoring of the Medicaid budget, preparation and distribution of statistical data and activities, and policy development regarding eligibility. In addition, contract development and negotiations are coordinated through this division. All Federal budget and statistical reports are prepared and submitted by this division. In conjunction with the Division of Claims Management, this division ensures that the Department's automated systems are appropriately updated to provide accurate and timely finance-related information. The division coordinates these functions through three branches: Administrative Services Branch, Eligibility Policy Branch, and Financial Management Branch.

Administrative Services Branch

This branch is responsible for the state plan and regulation system. This branch coordinates and maintains the Title XIX State Plan, provides administrative regulation coordination, legislation coordination, monitors the development of the intranet and the resource library, processes all open records requests, administers the Department's Decision Memos process, acts as Department liaison for legislative requests, and processes administrative hearings and appeals. This branch also reviews appropriate media to identify federal or state policy changes and program actions and refers issues to appropriate program divisions. This branch houses and is responsible for the following contracts:

- Passport Health Plan (PHP)-Region 3, Managed Care Organization;
- National Health Services (NHS)-Utilization review and External Quality Review programs; and
- Kentucky Transportation Cabinet Non-emergency Medical Transportation program.

Eligibility Policy Branch

This branch is primarily responsible for eligibility policy monitoring systems. This branch coordinates and maintains policy analysis, program research, program development regarding eligibility, establishes Medicaid third party liability policy as related to eligibility processes, provides technical assistance to the department and external agencies pertaining to eligibility criteria and systems, and ensures that internet resources related to eligibility are updated as needed.

Financial Management Branch

This Branch oversees the Department's administrative and benefit budgets as well as all financial transactions of the Department. Contract development and negotiations are coordinated through this Branch. All Federal budget and statistical reports are prepared and submitted by this branch. In conjunction with the Division of Claims Management, this Branch ensures that the Department's automated systems are appropriately updated to provide accurate and timely finance-related information. The branch is primarily responsible for audit coordination, rate

coordination/IGT coordination, and expenditure analysis and forecasting. With appropriate program staff input, this branch performs long and short term revenue and expenditure forecasting for the Department, performs financial impact analysis for newly proposed programs, proposed legislation, service or eligibility revisions for expansion, and conducts or sponsors actuarial studies of Medicaid of MCE service and demographic experience. In addition, they evaluate Managed Care Entities rate proposals in light of actuarial information, and maintain expertise necessary to provide technical assistance to program staff in support of their rate modeling and development responsibilities. In addition, staff develop contract compliance programs that continuously monitor the PHP, MHS and the Office of Transportation Delivery's compliance with contract terms.

Division of Hospitals & Provider Operations

(502) 564-6511

Mail Stop 6E-D

This division has direct responsibility for all Hospital, Physician and other specialty services. It is created to group together organizations with similar cost reporting requirements. This allows greater efficiency and effectiveness in determining rate structures for the organizations and in responding to the needs of these provider groups. This division is responsible for services and reimbursement for Inpatient Hospitals, Outpatient Hospitals, Acute Care Monitoring, Renal Dialysis Centers, Ambulatory Surgical Centers (ASC), Rehab Hospitals/Facilities, Comprehensive Outpatient Rehab Facilities, Critical Access Hospitals, Disproportionate Share Hospital (DSH) Policy, Renal Facilities, Psychiatric Hospitals, and Psychiatric Residential Treatment Facilities (PRTF's). The Division is also responsible for policy development and reimbursement functions, in both the fee-for-service, facility and managed care environments for the following programs: Physician (M.D.)/Osteopath, Dentist, Rural Health, Primary Care, Advanced Registered Nurse Practitioner (ARNP), Family Planning, Optometry/Opticians, Podiatry, Audiology, Physician Assistance, Birthing Centers, Durable Medical Equipment (DME), Specialty M.D.'s, Chiropractors, Speech, and outpatient free-standing X-ray. Finally, the Division of Hospitals and Provider Operations is accountable for all provider enrollment functions.

Hospitals Branch

This branch is primarily responsible for services reimbursement for Inpatient Hospitals, Outpatient Hospitals, Acute Care Monitoring, Renal Dialysis Centers, Ambulatory Surgical Centers (ASC), Rehab Hospitals/Facilities, Comprehensive Outpatient Rehab Facilities, Critical Access Hospitals, Disproportionate Share Hospital (DSH) Policy, and Transplants.

Physicians and Special Services Branch

This branch is responsible for policy development and reimbursement functions for the following programs: M.D./Osteopath, Dentist, Rural Health, Primary Care, Advanced Registered Nurse Practitioner (ARNP), Family Planning, Optometry/Opticians, Podiatry, Audiology, Physician Assistance, Birthing Centers, Durable Medical Equipment (DME), Specialty M.D.'s, Chiropractors, Speech, provider enrollment, and outpatient free-standing X-ray. The Director of the division has direct responsibility for the Physician Services, Dental Care, Podiatric Care, Nursing Services, Optometric Care and Primary Care Technical Advisory Committees.

Division of Long Term Care & Community Alternatives

(502) 564-7540

Mail Stop 6W-B

This division is responsible for program development and reimbursement functions of the long term care and Mental Health/Mental Retardation programs for the Commonwealth of Kentucky. The Division will coordinate these functions through two branches: the MH/MR Community Services Branch and the Long Term Care Branch.

MH/MR Community Services Branch

This branch is responsible for continuing departmental compliance with all applicable federal, state, and local laws and regulations related to long term care programs. These responsibilities shall include but not be limited to: research and compilation of data related to existing and potential long term care programs; development of waiver programs; amendments to and renewals of existing waiver programs; state plan amendments related to long term care programs; drafting and submittal of new administrative regulations for promulgation; amendments to current administrative regulations; drafting and issuance of long term care program manuals; reimbursement functions of long term care programs; monitoring of long term care providers to ensure compliance with program requirements as well as recipient safety and welfare; and any other support necessary for the implementation and operation of long term care programs. Long term care programs operated under the MH/MR Community Services Branch include: Home and Community Based Waiver, Model II Waiver, Adult Day Health Care, Home Health, Hospice, Personal Care Assistance Waiver, and Home Care Waiver.

Long Term Care Branch

This branch is responsible for continuing departmental compliance with all applicable federal, state, and local laws and regulations related to long term care facilities. These responsibilities shall include but are not limited to: continued research and data compilation regarding long term care facilities; amendments to current regulations; amendments to the state plan; reimbursement function of long term care facilities; monitoring of long term care facilities to ensure compliance with program requirements as well as recipient safety and welfare; and any other support necessary for the continuing operation of long term care facilities. Nursing, ventilator, brain injury, and swing beds are the facilities included in the operations of the Long Term Care Branch.

Division of Children's Health Insurance Program

(502) 564-6890

Mail Stop 6E-A

Provide strategic policy development and operational implementation and management to the Office of the Commissioner for Medicaid Services for the Kentucky Children's Health Insurance Program as follows: Develop and implement program policy and procedures, complying with the statutes and regulations of the State of Kentucky and the Federal government, as they apply to eligibility, cost sharing, covered benefits, provider participation, and claims processing. Administer the KCHIP program within state and federal guidelines including responsibility for budget and fiscal accountability, and reporting and management of program operation, accountability and evaluation.

Division of Claims Management

(502) 564-5183

Mail Stop 6W-D

This Division has the oversight responsibility for the contract with MMIS/Fiscal Agent. Staff of this division are responsible for provision of technical assistance to the Commissioner and Deputy Commissioner. This division is also responsible for policy development regarding eligibility, for resolving all recipient eligibility concerns, Utilization Review, and program integrity issues. The Division also provides technical support to the Department for Medicaid Services in all areas of information system development and management. The Division will coordinate these functions through two branches: the Recipient Claims Assistance Branch and the Claims Assistance Branch.

Recipient Claims Assistance Branch

This branch is responsible for maintaining a general Medicaid information help desk to field inquiries from the public and assistance to Medicaid recipients. Their responsibilities are as follow:

- Answer and log phone calls from recipients that come in through the Member Services toll free (800) phone number.
- Assist recipients with complaints and inquiries and do research when necessary.
- Answer and log recipient phone calls that come in through the KenPAC Help Desk toll free (800) phone number.
- Assist SSI KenPAC recipients in selecting or changing their KenPAC provider.
- Follow-up on requests sent by the Medicaid Ombudsman Office, LRC, Cabinet Secretary's Office, Governor's office and individual legislators related to Medicaid recipient issues.
- Responds to correspondence (Branch, Division, Department and Secretary).
- Respond to recipient correspondence related to HIPAA.
- Review Medicaid recipient materials for readability.
- Review and approve Passport recipient materials
- Maintain the Medicaid Member Guide.
- Provide administration support to the Consumer TAC.
- Other duties related to Medicaid recipients.

Claims Assistance Branch

This branch is responsible for developing, coordinating the procurement, maintaining and monitoring the MMIS contract. In addition, this branch serves as the Department liaison and monitors the performance of all external "feeder" Information Systems (KAMES, SDX, PA62, etc.), prepares and verifies accuracy and completeness of all routine and special management information reports, and serves as the department liaison to outside information management agencies. This branch is responsible for providing technical assistance to the Department in all areas of Information System development and management. They also assist program staff in the interpretation of data.

Division of Medical Management and Quality Assurance

(502) 564-9444

Mail Stop 6 E-C

This division is responsible for the formulation and monitoring of the Department's medical management, care coordination, and quality measurement of contractor's and internal programs. This division is responsible for the Department's development and oversight of utilization management, case management, disease management, customer service quality review, special children's' services, Quality State Plan, EQRO, MMIS, PRO, MCO and PBM contracts. The Department's Quality State Plan is prepared and submitted to CMS by this division. All Federal quality outcomes, indicators and medical standards are developed and reported in this division. This division is also responsible for development and updating of the standards of care for all disease states and provider/member education in accordance with national standards. The division coordinates these functions through two branches: Medical Management branch and Quality Assurance branch. Internal quality oversight of programs and staff performance is also included in this division.

Medical Management Branch

This branch coordinates and maintains the medical care coordination for the department, administrative regulation coordination for KenPAC and Lock-In, standards of care analysis, program development regarding the medical care of Medicaid's members. This branch researches and reviews current national standards of utilization management, disease management, and case management creating/reviewing educational material for contractors to use to educate the members, providers, prescribers, and internal staff in these processes. Reports are developed in this branch to review utilization of benefit packages and services. Providers, prescribers, and members' utilization patterns are reported and reviewed to ensure quality of care for the members and to report fraud and abuse.

This branch also holds Regional Nurse Consultant/Inspectors located out across the state. There are eight (8) regions across the state: Pikeville Region, Somerset Region, Bowling Green Region, Harlan Region, Newport Region, Hopkinsville Region, Ashland Region, and Owensboro Region. These NCI's assist providers and members alike with issues related to medical care and the reimbursement of these services. They perform care coordination and individual case management for Medicaid members. They research and report fraud and abuse as well.

Quality Assurance Branch

This branch is responsible for the quality review of all contracts, programs and services. This branch will develop the Department's state quality plan with input from all other divisions. The quality review of the administration of all service contracts will be coordinated in this division and reported to the personnel responsible for administrating the contracts. This branch will develop reports needed to accomplish this task.

Appendix A – List of Toll Free Numbers

Entity	Toll Free Number
ADA Coordinator Office for Kentucky	(877) 423-2933
Adult Abuse Hotline	(800) 752-6200
Adult Education & Literacy (Department for)	(800) 928-7323 V/TTY
Adult Lead Poisoning Questions	(502) 464-7360
Alcoholics Anonymous	(800) 467-8019
Business Info Clearing House (Licensing/Permit Info for New & Expanding Businesses)	(800) 626-2250
Cabinet for Families & Children Ombudsman	(800) 372-2973
Cabinet for Health Services Ombudsman	(877) 807-4027
Child Abuse Hotline	(800) 752-6200
Child Abuse Hotline (Childhelp National)	(800) 422-4453 TDD (800) 222-4453
Child Care Information	(800) 421-1903
Child Support Hotline	(800) 248-1163
Child Support Tax Refund Intercept Information	(800) 446-6041
Child Support Voice Response System	(800) 443-1576
Client Assistance Program (CAP)	(800) 633-6283
Commission of Deaf & Hard of Hearing	(800) 372-2907
Commission on Children with Special Health Care Needs (CCSHCN)	(800) 232-1160
Commission on Handicapped Children	(800) 232-1160
Commission on Human Rights	(800) 292-5566
Commission on Human Rights (For the Hearing and/or Speech Impaired)	(502) 595-4084
Consumer Protection Safety Commission	(800) 638-2772
Council on Child Abuse	(800) 432-9251
Crime Victims Information	(800) 372-2251
Crisis Information Service	(800) 592-3980
Department for the Blind	(800) 321-6668
Division of Mental Health (Consumers Only)	(800) 374-9146
Domestic Violence Hotline	(800) 432-9337
Domestic Violence Hotline (National)	(800) 799-7233 TDD (800) 787-3224
Drug Information Service of Kentucky	(800) 432-9337
EBT Card Replacement	(888) 979-9949
Election Fraud	(800) 328-8683
Federal Black Lung	(800) 638-7072
First Steps: Kentucky Early Intervention System	(800) 442-0087
Food Stamp Case Changes	(800) 248-5861
Food Stamp Information Line, Fayette County Residents	(859) 246-2516
Food Stamp Information Line, Jefferson County Residents	(502) 595-3636
Food Stamp Information Line, KY (except Fayette & Jefferson Counties)	(800) 931-9112
Foster Care Information	(800) 232-5437
GED on TV (KET)	(800) 538-4433
HIV/AIDS (CDC) National Hotline	(800) 342-2437
Home Health Agency Hotline	(800) 635-6290
Hospice Link	(800) 331-1620
HUD Discrimination Hotline	(800) 669-9777
KCHIP Information	(877) 524-4718
KCHIP Information (For the Hearing and/or Speech Impaired)	(877) 524-4719
KCHIP Information in Spanish	(800) 662-5397
KenPAC Help Desk	(877) 639-0010
Kentucky Access	(866) 405-6145

Kentucky Assistive Technology Loan Corp.	(800) 372-7172 (859) 246-2540 Ext. 237
Kentucky Assistive Technology Service Network	(800) 327-5287
Kentucky Association of Child Care Resources & Referral Agencies	(800) 723-5002
Kentucky Commission for Children with Special Healthcare Needs	(800) 232-1160
Kentucky Commission on Community Volunteerism & Service (KCCVS)	(800) 239-7404
Kentucky Commission on Human Rights	(800) 292-5566
Kentucky Department of Insurance	(800) 595-6053
Kentucky Developmental Disabilities Council	(877) 367-5332
Kentucky Housing Corporation (Information on buying homes & mortgage rates)	(800) 633-8896
Kentucky Independent Living Council	(800) 372-7172
Kentucky Office of Aging Services and State Health Insurance Assistance Program (SHIP)	(877) 293-7447
Kentucky Relay Service (for Hearing and/or Speech Impaired)	TDD Users call: (800) 648-6056 Voice Users call: (800) 648-6057 Customer Service call: (800) 662-2420
Kentucky Talking Book Library	(800) 372-2968
KET's GED on TV	(800) 538-4433
KY Commission of Deaf and Hard of Hearing	(800) 372-2907
Lead Poisoning (Adult) Questions	(502) 464-7360
Lead Poisoning (Child) Questions	(502) 564-2154
Learn to Read	(800) 372-7179
Legal Aid	(800) 292-1862
Legal Help for Aging Kentuckians	(800) 200-3633
Long Term Care Ombudsman	(800) 372-2991
Maternal and Child Health Information Line	(800) 635-2570
Medicaid Fraud & Abuse Hotline	(800) 373-2970
Medicaid Information for Providers-Voice Response (Eligibility Verification) Unisys Provider Assistance	(800) 807-1301
Medicaid Member Services-Questions/Issues from customers	(800) 635-2570
Medicaid Member Services-Questions/Issues from customers (for Hearing and/or Speech Impaired	(800) 775-0296
Medicaid Ombudsman	(877) 807-4027
Medicaid Ombudsman (for Hearing and/or Speech Impaired)	(877) 648-6056
Medicare	(800) 633-4227
Medicare (for Hearing and/or Speech Impaired)	(877) 486-2048
Medicare Durable Equipment Regional Center (DMERC)	(800) 213-5452
Medicare Home Health and Hospice Claims	(800) 583-2236
Medicare Part A and Part B Claims Administar Federal	(800) 999-7608
Medicare Part A and Part B Claims Administar Federal (for Hearing and/or Speech Impaired)	(866) 284-0881
Medicare Peer Review Organization (PRO)	(800) 288-1499
Missing Children (National Center for)	(800) 843-5678
National Domestic Violence Hotline (Interpreters available in various languages)	(800) 799-7233
National Youth Crisis Hotline	(800) 448-4663
Non-Emergency Transportation	(888) 941-7433
Nursing Home Ombudsman	(800) 372-2991
Office of Transportation Delivery (Information about Medicaid and KTAP Transportation)	(888) 941-7433
Ombudsman - CHS	(877) 807-4027 TTY: (800) 648-6056 Voice Relay: (800) 648-6057
Organ Donor (Kentucky)	(800) 525-3456
Parental Crisis Hotline/Parent Helpline	(800) 432-9251
Passport Health Plan Member Services	(800) 578-0603

Passport Health Plan Member Services (for Hearing and/or Speech Impaired)	(800) 691-5566
Poison Control Center	(800) 222-1222
Poison Emergency & Information Hotline	(800) 722-5725
Presumptive Eligibility-Questions/Issues from Providers	(866) 818-0073
Protection and Advocacy	(800) 372-2988
Railroad Retirees Part A Claims	(800) 999-7608
Railroad Retirees Part B Claims	(800) 808-0772
Railroad Retirees DME Claims	(800) 213-5452
Runaway Hotline (National)	(800) 231-6946
Runaway Switchboard (National)	(800) 621-4000
Sex Offender Alert Line	(866) 564-5652
Social Security/Medicare	(800) 772-1213
Special Needs Adoption	(800) 432-9346
Spouse Abuse Crisis Line	(800) 544-2022
United Mine Workers of America	(800) 843-8109
Vocational Rehab (Kentucky Only)	(800) 372-7172
Welfare Fraud	(800) 372-2970
Women, Infants and Children (WIC)	(800) 462-6122
Worker's Claims	(800) 554-8601

Appendix B – Commonly Used Acronyms

Acronym	Full Title/Name
AAPCC	Adjusted Average Per Capita Cost
AARP	American Association of Retired Persons
AASSP	AMERICORP Appalachian Self Support Program
ABAWD	Able Bodied Adults Without Dependents (FS Program)
ABC	Activity Based Costing
ABD	Aged, Blind, and Disabled
ABE	Adult Basic Education
ABI	Acquired Brain Injury
ABM	Activity Based Management
ACF	Administration for Children And Families (federal agency)
ACR	Adjusted Community Rate
ADA	Americans with Disabilities Act
ADC	Adult Day Care
ADD	Area Development District
ADHD	Attention Deficit Hyperactivity Disorder
ADL	Activities of Daily Living
AEVS	Automated Eligibility Verification System
AFCARS	Adoption & Foster Care Automated Reporting System
AFDC	Aid to Families with Dependent Children (replaced by TANF)
AFIA	Assets for Independence Act (under Title VI of COATESA)
AHA	American Hospital Association
AHCPR	Agency for Health Care Policy and Research (U.S.)
AHP	Accountable Health Plan
AIDS	Acquired Immuno-Deficiency Syndrome
AIS/MR	Alternate Intermediate Services / Mental Retardation
ALEC	American Legislative Exchange Council
ALEX	Automated Labor Exchange
ALJ	Administrative Law Judge
ALOS	Average Length of Stay
AMA	American Medical Association
AMI	Acute Myocardial Infarction
ANSI	American National Standards Institute
AOC	Administrative Office of the Courts
AP	Absent Parent
APC	Ambulatory Payment Classification
APCC	Adjusted Per Capita Cost
APD	Advanced Planning Document
APDRG	All Patient Diagnosis Related Groups
APDU	Advanced Planning Document Update
APHSA	American Public Human Services Administration (formerly APWA)
APR	Adjusted Payment Rate
APS	Absent Parent Search
APS	Adult Protective Services
APSCBT	Adult Protective Services Competency Based Training
APWA	American Public Welfare Association
ARNP	Advanced Registered Nurse Practitioners
ASAP	As Soon As Possible
ASC	Ambulatory Surgical Center
ASFA	Adoption & Safe Families Act
ASO	Administrative Services Organization
ASR	Age/Sex Rates
ASSPA	AFDC Spousal Support Averages

AWP	Average Wholesale Price
BBA	Balanced Budget Act of 1997 (BBA for various other years as well)
BCCTP	Breast & Cervical Cancer Treatment Program
BIPA	Medicare, Medicaid & SCHIP Benefits Improvement & Protection Act of 2000
BL	Black Lung
BOW	Birth Out of Wedlock
BRFSS	Behavioral Risk Factor Surveillance System
BSADD	Big Sandy Area Development District
BUA	Basic Utility Allowance
BWE	Blind Work Expense
CAP	Christian Appalachian Project
CAP	Community Action Program
CAPTA	Child Abuse & Prevention Treatment Act of 1974
CARE	Charity Aid, Recovery, and Empowerment Act
CARE	Comprehensive AIDS Resources Emergency Act
CASA	Court Appointed Special Advocate
CATS	Commonwealth Accountability Testing System
CATS	Comprehensive Assessment & Training Service
CBIS	Central Billing & Information System
CC	Child Care
CC	Collateral Contact
CCAP	Child Care Assistance Program (CFC program)
CCC	Community Collaboration for Children
CCDBG	Child Care and Development Block Grant
CCDF	Child Care Development Fund
CCF	Claim Correction Form
CCFP	Child Care Food Program
CCR	Change Control Request
CCSHCN	Commission on Children with Special Health Care Needs
CCTK	Child Care Transitioning from K-TAP
CCU	Critical Care unit
CCU	Coronary Care Unit
CDA	Child Development Associate
CDBG	Community Development Block Grant
CDC	Centers for Disease Control & Prevention
CDW	Court Designated Worker
CE	Categorically Eligible
CFC	Cabinet for Families & Children
CFCRB	Citizens Foster Care Review Board
CFE	Clinical Forensic Examination
CFR	Code of Federal Regulations
CFS	Comprehensive Family Services
CHAMPUS	Civilian Health & Medical Program of the Uniformed Services
CHD	Coronary Heart Disease
CHF	Chronic Heart Failure
CHIP	Children's Health Insurance Program
CHR	Cabinet for Human Resources (now split into CHS & CFC)
CHS	Cabinet for Health Services
CINS	Commonwealth Integrated Network Systems
CLAS	Culturally & Linguistically Appropriate Services
CLIA	Clinical Laboratory Improvement Amendment
CM	Cash Management Specialist
CMHC	Community Mental Health Center
CMHS	Center for Mental Health Services
CMI	Case-Mix Index
CMP	Competitive Medical Plan

CMS	Centers for Medicare & Medicaid (formerly HCFA)
CMSO	Center for Medicaid and State Operations (CMS Agency)
COA	Council on Accreditation
COATESA	Community, Opportunity, Accountability, and Training & Educational Services Act of 1998
COB	Close Of Business
COB	Coordination of Benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act 1985
COLA	Cost Of Living Adjustment
CON	Certificate of Need
CORF	Comprehensive Outpatient Rehabilitation Facility
CPAS	Claims Processing Assessment System
CPI	Consumer Price Index
CPR	Customary, Prevailing, and Reasonable
CPR	Cardio Pulmonary Resusitation
CPS	Child Protective Services
CPS	Current Population Survey
CPSCPSCBT	Child Protective Services Competency Based Training
CPT	Current Procedural Terminology
CQI	Continuous Quality Improvement
CRIPA	Civil Rights of Institutionalized Persons Act
CRNA	Certified Registered Nurse Anesthetist
CS	Client's Statement Accepted
CSA	Client's Statement Accepted
CSA/MAPP	Foster Parent Training for Children of Sexual Abuse
CSP	Community Service Program
CSR	Customer Service Request
CSV	Cash Surrender Value
CWEP	Community Work Experience Program
DCBS	Department for Community Based Services (in CFC)
DCC	Division of Child Care
DCFM	Division of Clinical Forensic Medicine
DCR	Design Change Request
DCS	Division of Child Support (in CFC)
DCSR	Daily Case Status Report
DD	Developmentally Disabled
DDDS	Department for Disability Determination Services
DED	Data Element Dictionary
DEERS	Defense Eligibility Enrollment Reporting System
DEFRA	Deficit Reduction Act (1984)
DEIC	District Early Intervention Committee
DEP	Deprivation
DES	Department for Employment Services
DFAB	Drug Formulary Advisory Board
DFS	Division of Family Support (in CFC)
DHHS	Department of Health & Human Services (U.S.)
DIS	Department of Information Systems (now known as GOT)
DJJ	Department for Juvenile Justice
DL	Driver's License
DMD	Division of Management & Development
DME	Durable Medical Equipment
DMO	Disease Management Organization
DMRAB	Drug Management Review Advisory Board
DMS	Department for Medicaid Services
DNR	Do-Not-Resuscitate
DOB	Date Of Birth
DOS	Date of Service

DPP	Disproportionate Patient Percentage (related to DSH)
DPP	Division for Protection & Permanency (in CFC)
DRF	Discrepancy Report Form
DRG	Diagnosis Related Group
DSH	Disproportionate Share Hospital
DSM	Diagnostic and Statistical Manual
DSS	Department for Social Services (replaced by DPP)
DUR	Drug Utilization Review
DURAB	Drug Use Review Advisory Board
Dx	Diagnosis
E & T	Employment & Training
EAL	Everyone's A Leader
EAST KY CCC	East Kentucky Child Care Coalition
EBRI	Employee Benefit Research Institute
EBT	Electronic Benefit Transfer
ECC	Electronic Claims Capture
ECEPD	Early Childhood Educator Professional Development Program
ECM	Electronic Claims Management
ECO	Emergency Custody Order
EDI	Electronic Data Interchange
EEO	Equal Employment Opportunity
EITC	Earned Income Tax Credit
EKCEP	Eastern Kentucky Concentrated Employment Program
ELO	Each Local Office
EMC	Electronic Media Claims
EMS	Emergency Medical Services
EOB	Explanation of Benefits
EPA	Exclusive Provider Arrangement
EPO	Emergency Protective Order
EPSDT	Early & Periodic Screening, Diagnosis & Treatment
ERISA	Employee Retirement Income Security Act of 1974
ERP	Employment Reimbursement Program
ERS	Employment retention Specialist
ESB	Eligibility Services Branch (in DCBS)
ESI	Employer-Sponsored Insurance
ETP	Employment Training Program
EVS	Eligibility Verification System
FACTS	Families And Children Together Safe
FAD	Family Alternative Diversion
FAQ	Frequently Asked Questions
FAS	Fetal Alcohol Syndrome
FCCH	Family Child Care Home (in CFC)
FCCW	Family Child Care Worker (in CFC)
FDA	Food & Drug Administration
FDIC	Federal Deposit Insurance Corporation
FDP	Factitious Disorder by Proxy
FDRS	Family Day Care Rating Scale
FEHBP	Federal Employees Health Benefits Program
FEIN	Federal Employer Identification Number
FEP	Federal Employee Health Benefit Program
FFP	Federal Financial Participation
FFS	Fee-For-Service
FFY	Federal Fiscal Year
FICA	Federal Insurance Contributions Act
FIPS CODE	Federal Information Processing Standard Code
FLO	Family Level Object

FLSA	Fair Labor Standards Act
FMAC	Federal Maximum Allowable Cost
FMAP	Federal Medicaid Assistance Percentage
FNS	Food & Nutrition Service (in USDA)
FOCUS	Furthering Our Children's United Services
FPL	Federal Poverty Level
FPLS	Federal Parent Locator Service
FPO	Foreign Protective Order (out-of-state)
FPP	Family Preservation Program
FQHC	Federally Qualified Health Center
FRC	Family Resource Centers
FRP	Family Reunification Program
FRYSC	Family Resource Youth Services Center
FS	Family Services
FS or FSP	Food Stamp Program
FSCBT	Family Services Competency Based Training
FSOS	Family Services Office Supervisor
FSS	Family Support Specialist
FSS	Field Services Supervisor (in CFC)
FSW	Family Services Worker (in CFC)
FTE	Full Time Equivalent
FTT	Failure To Thrive
FUTA	Federal Unemployment Tax Act
FYI	For Your Information
GA	General Assistance
GAF	Geographic Adjustment Factor
GAL	Guardian Ad Litem
GAO	General Accounting Office (federal agency)
GC	Good Cause
GED	General Equivalency Diploma
GIS	Geographic Information System
GJS	Group Job Search
GOT	Governor's Office of Technology (formerly known as DIS)
GPCI	Geographic Practice Cost Index
GPS/MAPP	Group Preparation & Selection/Model Approach partner Parenting
GUI	Graphical User Interface
HA	Housing Authority
HANDS	Health Access Nurturing & Development Services
HB	House Bill
HCB	Home & Community Based
HCB/ADC	Home & Community Based Services through Adult Day Care
HCBC	Home & Community Based Care
HCBS	Home & Community Based Services
HCFA	Health Care Financing Administration (now known as CMS)
HCPCS	HCFA Common Procedure Coding System
HCPP	Health Care Prepayment Plan
HEAP	Home Energy Assistance Program
HEDIS	Healthplan Employer Data and Information Set
HEROS	Honoring Excellence & Rewarding Outstanding Employee Service (in CFC)
HH	Household
HHM	Household Member
HHS	Department of Health & Human Services (federal agency)
HIB	Hospital Insurance Benefit (Medicare Part A)
HIC Number	Health Insurance Claim Number
HIFA	Health Insurance Flexibility & Accountability Demonstration Initiative
HIPAA	Health Insurance Portability and Accountability Act of 1996

HIPC	Health Insurance Purchasing Cooperative
HIPP	Health Insurance Premium Payment Program
HIPPS	Health Insurance Premium Payment System
HMO	Health Maintenance Organization
HOH	Head Of Household
HPSA	Health Professional Shortage Area
HSCC	Human Services Coordinator's Council
HUD	U.S. Department of Housing and Urban Development
HW	HealthWatch
ICC	Interagency Coordinating Council
ICD	International Classification of Disease
ICD-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modification
ICF	Intermediate Care Facility
ICF-MR	Intermediate Care Facility/Mental Retardation
ICF-MR-DD	Intermediate Care Facility for the Mentally Retarded or Developmentally Disabled
ICU	Intensive Care Unit
ID	Identification
IDA	Individual Development Accounts
IDE	Investigational Device Exemption
IDEA	Individuals with Disabilities Education Act
IEPA	Inter Ethnic Provisions Act
IFBSS	Intensive Family Based Support Services
IGT	Inter-Governmental Transfer
IIPS	Internet Information Processing System
IJS	Individual Job Search
ILO	Individual Level Object
IM	Income Maintenance
IMD	Institution For Mental Disease
IME	Indirect Medical Education
IMPACT	Interagency Mobilization for Progress in Adolescent & Children's Treatment
IP	Integrated Provider
IPA	Independent Practice Association
IPV	Intentional Program Violation
IRB	Institutional Review Board
IRC	Internal Revenue Code
IRS	Internal Revenue Service
ISN	Integrated Service Networks
ISP	Internet Service Provider
ITERS	Infant/Toddler Environmental Rating Scale
ITIN	Individual Tax Identification Number
IV-A	Title IV-A of the Social Security Act (K-Tap Program)
IV-D	Title IV-D of the Social Security Act (Child Support Program)
IV-E	Title IV-E of the Social Security Act (Foster Care Program)
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCL	Job Control Language or its equivalent
JRA	Job Readiness Activity
JSST	Job Seeking Skills Training
JTPA	Job Training Partnership Act
KACCRRA	Kentucky Association of Child Care Resource & Referral Agencies
KADAP	Kentucky Aids Drug Assistance Program
KAECE	Kentucky Association for Early Childhood Education
KAMES	Kentucky Automated Management & Eligibility System
KAR	Kentucky Administrative Regulations
KASES	Kentucky Automated Support Enforcement System
KASPER	Kentucky All Schedule Prescription Electronic Reporting
KC	Kinship Care Program

KCCMS	Kentucky Child Care Management System (in CFC)
KCHIP	Kentucky Children's Health Insurance Program
KCPC	Kentucky Correctional Psychiatric Center
KCTCS	Kentucky Community & Technical College System
KDE	Kentucky Department of Education
KDVA	Kentucky Domestic Violence Association
KECC	Kentucky Employee Charitable Campaign
KEIES	Kentucky Early Intervention & Evaluation System
KEIN	Kentucky Employer Identification Number
KEIS	Kentucky Early Intervention System
KEIS-ICC	Kentucky Early Intervention System - Interagency Coordinating Council
KenPAC	Kentucky Patient Access & Care
KERA	Kentucky Education Reform Act
KHA	Kentucky Hospital Association
KHC	Kentucky Housing Corporation
KHEA	Kentucky Higher Education Authority
KHIPP	Kentucky Health Insurance Premium Payment Program
KHS	Kentucky Headstart Association
KIECPD	Kentucky Institute for Early Childhood Professional Development
KIH	Kentucky Information Highway
KMA	Kentucky Medical Association
KPA	Kentucky Pharmacy Association
KPC	Kentucky Physician's Care
KRADD	Kentucky River Area Development District
KRS	Kentucky Revised Statutes
KSP	Kentucky State Police
KTAP	Kentucky Transitional Assistance Program
KWP	Kentucky Works Program
KYCSACC	Kentucky Coalition for School-Age Child Care
KYIAYC	Kentucky I Am Your Child
KYIMS	Kentucky Information Management System
KYNET	Kentucky Network
KY-WINS	Kentucky Workforce Investment Network System
LAN	Local Access Network
LEO	Law Enforcement Official
LIHEAP	Low Income Heat Energy Assistance Program
LINK	Law Enforcement Network Of Kentucky
LL	Landlord
LOS	Length of Stay
LTC	Long Term Care
MA	Medical Assistance
MAC	Maximum Allowable Cost
MAID	Medical Assistance Identification Number
MAP	Medical Assistance Program
MARS	Management Administrative & Reporting System
MART	Medical Assistance Revolving Trust fund
MBP	Munchausen Syndrome by Proxy
MCBS	Medicare Current Beneficiary Survey
MCCC	Mountain Comprehensive Care Center
MCO	Managed Care Organization
MCR	Medicare Cost Report
MDS	Minimum Data Set
MedPAR	Medicare Provider Analysis & Review
MEI	Medicare Economic Index
MEPA	Multi-Ethnic Placement Act
MEPS	Medical Expenditure Panel Survey

MEQC	Medicaid Eligibility Quality Control
MET	Multiple Employer Trust
MH/MR	Mental Health / Mental Retardation
MMIS	Medicaid Management Information System
MOA	Memorandum of Agreement
MOE	Maintenance Of Effort
MOU	Memorandum of Understanding
MPI	Medicaid Price Indicator
MQC	Medicaid Quality Control
MQT	Medicaid Quality Tracking
MRT	Medical Review Team
MSA	Medical Savings Account
MSE	Medical Support Enforcement
MTL	Manual Transmittal Letter
NAEYC	National Association for the Education of Young Children
NAFCC	National Association for Family Child Care
NAFTA	North American Free Trade Act
NAHO	National Association of Hearing Officers
NAMI	National Alliance for the Mentally Ill
NAT	Nurse Aide Training
NCANDS	National Child Abuse & Neglect Data System
NCH	National Claims History System
NCIC	National Crime Information Center
NCP	Non-Custodial Parent
NCPCA	National Committee for Prevention of Child Abuse
NCPDP	National Council of Prescription Drug Programs
NCQA	National Committee for Quality Assurance
NDAS	National Data Analysis System
NDC	National Drug Code
NECPA	National Early Childhood Program Accreditation
NEMT	Non-Emergency Medical Transportation
NF	Nursing Facility
NF	Nursing Facility
NHIS	National Health Interview Survey
NIMH	National Institute of Mental Health
NMHA	National Mental Health Association
NPI	National Provider Identifier
NSACA	National School-Age Care Alliance
NSAF	National Survey of America's Families
NSAID	Non-Steroid Anti-Inflammatory Drug
OAG	Office of the Attorney General
OASDI	Office of Aging Services
OASDI	Old-Age, Survivors and Disability Insurance
OBRA	Omnibus Budget Reconciliation Act
OCR	Office of Civil Rights (federal agency)
OCSE	Office of Child Support Enforcement (federal agency)
OIG	Office of the Inspector General
OJT	On-the-Job Training Program
OMB	Office of Management & Budget
OMH	Office of Minority Health (federal agency)
OPE	Office of Performance Enhancement
OPPS	Outpatient Prospective Payment System
OR	Original Record
ORPS	Occurrence Reporting And Processing System
ORR	Office of Refugee Resettlement (federal agency)
OSB	Operations Support Branch (in DCBS)

OTS	Office of Technology Services
P&P	Protection & Permanency
PA	Physicians Assistant
PA	Prior Authorization
PA	Public Assistance
PACE	Program of All-inclusive Care for the Elderly
PARB	Program Assistance & Resource Branch (in DCBS)
PASS	Plan for Achieving Self Support
PC	Personal Computer
PCA	Personal Care Attendant
PCCM	Primary Care Case Management
PCP	Primary Care Provider
PHA	Public Housing Agency
PHI	Protected Health Information
PHO	Physician Hospital Organization
PHP	Passport Health Plan/Region 3 Partnership
PIC	Private Industry Council
PMA	Pre-Market Approval
POS	Point Of Service
PPLA	Planned Permanent Living Arrangement
PPO	Preferred Provider Organization
PPS	Prospective Payment System
PRO	Peer Review Organization
PRP	Personal Responsibility Plan
PRTF	Psychiatric Residential Treatment Facility
PRWORA	Personal Responsibility & Work Opportunity Reconciliation Act-1996
PSRO	Professional Standards Review Organization
PTSD	Post Traumatic Stress Disorder
PWE	Principal Wage Earner
QC	Quality Control
QCI	Quality Care Initiative
QDWI	Qualified Disabled Working Individual
QI-1	Qualified Individual - Group 1
QI-2	Qualified Individual - Group 2
QIO	Quality Improvement Organization (new name used by feds for PRO)
QMB	Qualified Medicare Beneficiaries
QMHP	Qualified Mental Health Professional
QP	Qualifying Parent
R&C	Recruitment & Certification (Foster Care)
RA	Remittance Advices
RAP	Relocation Assistance Program
RBRVS	Resource Based Relative Value Scale
RDS	Report Distribution System
RDUR	Retrospective Drug Utilization Review
RFA	Request For Application
RFI	Request For Information
RFP	Request For Proposal
RHC	Rural Health Clinics
RHCIA	Rural Health Care Improvement Act of 2001
RIAC	Regional InterAgency Council
RIPO	Read Initial & Pass On
RMDS	Report Management Distribution System
RMTS	Random Moment Time Study
RSD	Requirements Specification Document
RSDI	Retired, Survivors, & Disability Insurance
RTC	Regional Training Coordinator

RUG	Resource Utilization Grouping
RVS	Relative Value Scale
RVU	Relative Value Unit
Rx	Prescription Drug
SACERS	School Age Care Environmental Rating Scale
SACWIS	State Automated Child Welfare Information System
SAMHSA	Substance Abuse & Mental Health Services
SAS	Strategic Alliance Services
SB	Senate Bill
SBS	Shaken Baby Syndrome
SCHIP	State Children's Health Insurance Program
SCL	Supports for Community Living
SDA	Service Delivery Area
SDD	System Design Document
SDX	State Data Exchange
SED	Secondary Education
SFY	State Fiscal Year
SHIP	State Health Insurance Program
SIDS	Sudden Infant Death Syndrome
SIPP	Survey of Income and Program Participation
SLMB	Specified Low Income Medicare Beneficiary
SMI	Supplemental Medical Insurance (MEDICARE Beneficiaries)
SMM	State Medicaid Manual
SNAP	Special Needs Adoption Program
SNF	Skilled Nursing Facility
SOBRA	Sixth Omnibus Budget Reconciliation Act
SOLQ	State On-Line Query
SOP	Standards of Practice
SP	Second Parent
SPA	State Plan Amendment (to the state's Title XIX Medicaid State Plan)
SPLS	State Parent Locator Service
SR	Specified Relative
SRA	Service Region Administrator (in CFC)
SRAA	Service Region Administrator Associate (in CFC)
SRAC	Service Region Advisory Council
SRCA	Service Region Clinical Associate (in CFC)
SS	Social Security
SSA	Social Security Administration
SSBG	Social Services Block Grant
SSI	Supplemental Security Income
SSN	Social Security Number
SSP	State Supplementation Payment
SSS	Social Services Specialist (in CFC)
STEP	System Tracking Employability Program
STT	Short Term Training
SUA	Standard Utility Allowance
SUR	Surveillance and Utilization Review
SURS	Surveillance and Utilization Review Subsystem
SVTS	Sandy Valley Transportation Services
SW	Social Worker (in CFC)
TAA	Transitional Assistance Agreement
TAA	Trade Adjustment Assistance
TAC	Technical Advisory Committee
TANF	Temporary Assistance for Needy Families
TAP	Transitional Assistance Program
TCC	Transitional Child Care

TCM	Targeted Case Management
TCN	Transaction Control Number
TDD	Telecommunications Device for the Deaf
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982
TEL	Tax Expenditure Limitation
TITLE IV-A	Title XIX of the Social Security Act - Authorizes AFDC Program
TITLE XIX	Title XIX of the Social Security Act - Authorizes Medicaid Program
TITLE XXI	Title XIX of the Social Security Act - Authorizes Children's Health Insurance Program (CHIP)
TMA	Transitional Medical Assistance
TPA	Third Party Administrator
TPL	Third Party Liability
TPR	Termination of Parental Rights
TRICARE	Formerly CHAMPUS
TRIS	Training Records Information System
TWIST	The Workers Information System
TWWIIA	Ticket to Work & Work Incentives Improvement Act (1999)
UB-92	Unified Billing-Form 92
UCR	Usual, Customary, and Reasonable
UI	Unemployment Insurance
UIB	Unemployment Insurance Benefit
UIFSA	Uniform Interstate Family Support Act
UP	Unemployed/Underemployed Parent
UPIN	Unique Provider Identifying Number
UPPS	Universal Personnel & Payroll System
UR	Utilization Review
URISA	Uniform Interstate Family Support Act
USCB	United States Census Bureau
USDA	United States Department of Agriculture
VA	U.S. Veterans Administration
VAW	Violence Against Women
VES	Vocation Education Skills
VINE	Victim Information And Notification Everyday System
VPN	Virtual Private Network
VPS	Volume Performance Standard System
WAN	Wide Area Network
WC	Workman's Compensation
WEP	Work Experience Program
WEP	Wired Equivalent Privacy (WiFi equipment comes with an encryption system known as WEP)
WIA	Workforce Investment Act
WIC	Supplemental Nutritional Program for Women, Infants & Children
WiFi	Wired Fidelity
WPA	WiFi Protected Access
WtW	Welfare to Work

Appendix C – Commonly Used Terms

Term	Definition
Abuse	When used as a legal term in healthcare, normally refers to actions that do not involve intentional misrepresentations in billing but which, nevertheless, result in improper conduct. Consequences can result in civil liability & administrative sanctions. An example is the excessive use of medical supplies.
Acceptance Testing	Method by which a system developed/installed by a contractor is tested by User/Purchaser to assure that the system meets stated requirements.
Access	Access is an individual's ability to obtain appropriate health care services. Barriers to access can be financial (insufficient monetary resources), geographic (distance to providers), organizational (lack of available providers) and sociological (e.g., discrimination, language barriers). Efforts to improve access often focus on providing or improving health coverage.
Accountable Health Partnership	An organization of doctors and hospitals which provides care for people organized into large groups of purchasers.
Accountable Health Plan (AHP)	A plan that would offer a nationally defined package of specified benefits and provide consumers with a report card on the quality and services offered by the plan.
Accreditation	The process by which an organization recognizes a program of study or an institution as meeting predetermined standards. Two organizations that accredit managed care plans are the National Committee for Quality Assurance (NCQA) and the Joint Commission on Accreditation of Health Care Organizations (JCAHO).
Accrete	The addition of new recipients to a health plan (Medicare term).
Activities of Daily Living (ADL)	An index or scale that measures an individual's degree of Independence in bathing, dressing, using the toilet, eating, and moving across a small room (bathing, dressing, eating, toileting, transferring, ambulating, and incontinence). ADLs are often used as an assessment tool to determine an individual's ability to function at home, or in a less restricted environment of care.
Activity-Based Costing (ABC)	Activity-based costing defines healthcare costs in terms of a healthcare organization's processes or activities. The costs are then associated with significant activities or events. It relies on the following 3 step process: (1) Activity mapping, which involves mapping activities in an illustrated sequence; (2) Activity analysis, which involves defining and assigning a time value to activities; and, (3) bill of activities, which involves generating a cost for each main activity.
Activity-Based Management (ABM)	Activity-Based Management supports operations by focusing on the causes of costs and how costs can be reduced. It assesses cost drivers that directly affect the cost of a product or service, and uses performance measures to evaluate the financial or non-financial benefit an activity provides. By identifying each cost driver and assessing the value the element adds to the healthcare enterprise, ABM provides a basis for selecting areas that can be changed to reduce costs.
Actuarial	Refers to the statistical calculations used to determine the managed care company's rates and premiums charged their customers based on projections of utilization and cost for a defined population.
Acute Care	A pattern of health care in which a patient is treated for an acute (immediate & severe) episode of illness, for subsequent treatment of injuries related to an accident or other trauma, or during recovery from surgery. Acute care is usually given in a hospital by specialized personnel using complex & sophisticated technical equipment and materials. Unlike chronic care, acute care is often necessary for only a short time.
Adjudicated Claim	A claim which has been processed to final disposition either paid or denied.
Adjusted Admissions	A measure of all patient care activity undertaken in a hospital, both inpatient and outpatient. Adjusted admissions are equivalent to the sum of inpatient admissions and an estimate of the volume of outpatient services. This estimate is calculated by

	multiplying outpatient visits by the ratio of outpatient charges per visit to inpatient charges per admission.
Adjusted Average Per Capita Cost (AAPCC)	(1) Actuarial projections of per capita Medicare spending for enrollees in fee-for-service Medicare. Separate AAPCCs are calculated (usually at county level) for Part A services & Part B services for the aged, disabled, and people with ESRD. Medicare pays risk plans by applying adjustment factors to 95% of the Part A & Part B AAPCCs. The adjustment factors reflect differences in Medicare per capita fee-for-service spending related to age, sex, institutional status, Medicaid status, and employment status. (2) A county-level estimate of the average cost incurred by Medicare for each beneficiary in fee for service. Adjustments are made so that the AAPCC represents the level of spending that would occur if each county contained the same mix of beneficiaries.
Adjusted Community Rate (ACR)	A process by which a health plan contracting with Medicare estimates the cost of providing services to its Medicare enrollees based on costs and revenues from its commercial business. Health plans estimate their ACRs annually and adjust the subsequent year's supplemental benefits or premiums offered so that they do not receive a higher rate of return on Medicare enrollees than they do on their commercial business.
Adjusted Drug Benefit List	A small number of medications often prescribed to long-term patient. Also called a drug maintenance list. It can be modified from time to time by a health plan, HCFA or 3rd party administrator.
Adjusted Payment Rate	The Medicare capitated payment to risk-contract HMOs. For a given health plan, the
(APR)	APR is determined by adjusting county-level AAPCCs to reflect the relative risks of the plan's enrollees.
Adjusted Per Capita Cost (APCC)	Medicare benefits estimation for a person in a given county using sex, age, institutional status, Medicaid disability, and end stage renal disease status as a basis.
Administrative Services Only (ASO)	A relationship between an insurance company or other management entity and a self-funded plan or group of providers in which the insurance company or management entity performs administrative services only, such as billing, practice management, marketing, etc., and does not assume any risk. The client bears the financial risk for the claims. Clients contracting for ASO can include health plans, hospitals, delivery networks, IPAs, etc. A provider system wishing to capitate may contract with a TPA for ASO for certain services for which the provider group does not want to bring in house. This is a form of outsourcing.
Administrative Services Organization (ASO)	A contract between an insurance company and a self-funded plan where the insurance company performs administrative services only and the self-funded entity assumes all risk.
Adult Day Care	A licensed day care program providing personal care, supervision, and assistance in eating, bathing, dressing, toileting, moving about and taking medications.
Advance Directive	A statement about a person's future wishes about treatment in the event that the individual is unable to make competent decisions at a later date. "Advance directive" often refers specifically to living wills, healthcare proxies, and do-not-resuscitate (DNR) orders.
Adverse Selection	Adverse selection is a tendency for utilization of health services in a population group to be higher than average. Adverse selection occurs when a larger proportion of persons with poorer-than-average health status apply for, or continue in specific plans or insurance options, while a larger proportion of persons with better-than-average health status enroll in other plans or insurance options. Thus, the plans with the subpopulation with poorer-than-average health have costs which are not covered by the premium.
Advocate	A person, often a family member, who is designated to speak with healthcare providers on behalf of a patient. An advocate does not have legal powers, unlike a healthcare proxy.

Age/Sex Rates (ASR)	Also called table rates, they are given group products' set of rates where each grouping, by age and sex, has its own rates. Rates are used to calculate premiums for group billing and demographic changes are adjusted automatically in the group.
Age-at-Issuance Rating	A method for establishing health insurance premiums whereby an insurer's premium is based on the age of individuals when they first purchased health insurance coverage. This is an older form of actuarial assessment.
Age-Attained Rating	Similar to the Age-at-Issuance Rating, this method for establishing health insurance premiums whereby an insurer's premium is based on the current age of the beneficiary. Age-attained-rated premiums increase in price as the purchasers grow older.
Aggregate Indemnity	The maximum payment amount provided in cash by an insurer for each covered service. An indemnity insurance contract usually defines the amounts.
Aggregate Margin	This is computed by subtracting the sum of expenses for all hospitals in the group from the sum of revenues and dividing by the sum of revenues. The aggregate margin compares revenues to expenses for a group of hospitals, rather than one single hospital.
Aggregate Stop Loss	The form of excess risk coverage that provides protection for the employer against accumulation of claims exceeding a certain level. This is protection against abnormal frequency of claims in total, rather than abnormal severity of a single claim.
Aid to Families with Dependent Children (AFDC)	The federal AFDC program was established by the Social Security Act of 1935 which provided cash welfare to needy children (and their caretakers) who lacked support because at least one parent was unavailable. Families had to meet income and resource criteria specified by the state to be eligible. States administered the AFDC program with funding from both the federal government and state. The Personal Responsibility & Work Responsibility Act of 1996, enacted in August 1996, replaced AFDC with a new block grant program Temporary Assistance for Needy Families(TANF), but AFDC standards are still retained for use in Medicaid.
All Patient Diagnosis Related Groups (APDRG)	An enhancement of the original DRGs, designed to apply to a population broader than that of Medicare beneficiaries, who are predominately older individuals. The APDRG set includes groupings for pediatric and maternity cases as well as of services for HIV-related conditions and other special cases.
Allowable Costs	Covered expenses within a given health plan. Items or elements of an institution's costs which are reimbursable under a payment formula. Both Medicare and Medicaid reimburse hospitals on the basis of only certain costs. Allowable costs may exclude, for example, luxury travel or marketing. HCFA publishes an extensive list of rules governing these costs and provides software for determining costs. Normally the costs which are not reasonable expenditures, which are unnecessary, which are for the efficient delivery of health services to persons covered under the program in question are not reimbursed. The most common form of cost reimbursement is the "cost report" methodology used for DRG-exempt services, such as many out-patient hospital based programs, long-term care and skilled nursing units, physical rehab, psychiatric and substance abuse inpatient programs. Some specialty hospitals receive all of their HCFA reimbursement as cost based reimbursement.
Allowed Charge	The amount Medicare approves for payment to a physician. Typically, Medicare pays 80% of the approved charge and the beneficiary pays the remaining 20%. The allowed charge for a nonparticipating physician is 95% of that for a participating physician. Nonparticipating physicians may bill beneficiaries for an additional amount above the allowed charge.
All-Payer System	A system in which prices for health services and payment methods are the same, regardless of who is paying. For instance, in an all-payer system, federal or state government, a private insurer, a self-insured employer plan, an individual, or any other payer could pay the same rates. The uniform fee bars health care providers from shifting costs from one payer to another.

Alternate Delivery Systems	Health services provided in other than an inpatient, acute-care hospital or private practice. Examples within general health services include skilled and intermediary nursing facilities, hospice programs, and home health care. Alternate delivery systems are designed to provide needed services in a more cost-effective manner. Most of the services provided by community mental health centers fall into this category.
Ambulatory Care	Health services provided without the patient being admitted. Also called outpatient care. Services may include diagnosis, treatment, surgery, and rehabilitation. The services of ambulatory care centers, hospital outpatient departments, physicians' offices and home health care services fall under this heading provided that the patient remains at the facility less than 24 hours. No overnight stay in a hospital is required.
Ambulatory Payment Classification (APC)	The basic unit of payment in the Medicare Prospective Payment System for outpatient visits or procedures will be the APC. Under the APC system, outpatient services and procedures are classified for purchases of payment (similar to DRGs). The APC system classifies some 7,000 services and procedures into 346 procedures groups.
Ambulatory Surgical Center (ASC)	A free-standing facility certified by Medicare that performs certain types of types of procedures on an outpatient basis.
American National Standards Institute (ANSI)	A national organization founded to develop voluntary business standards in the United States.
Ancillary Services	Supplemental services, including laboratory, radiology, physical therapy, and inhalation therapy that are provided in conjunction with medical or hospital care.
Application Integrators	Software that transparently provides application-to-application functionality, primarily through data conversion and transmission, while eliminating the need for custom programming. Also referred to as application integration gateway, application interface gateway, integration engine, intelligent gateway. This type of software is key to developing networks of information systems, making client-specific information available in real time to all members of an IHDS.
ASC-Approved Procedure	A procedure approved by Medicare for payment in the ASC. A procedure is approved if it can be performed safely in the outpatient setting, if it was performed in the inpatient setting at least 20% of the time when it was approved, and if it is performed in physicians' offices no more than 50% of the time. (HCFA)
Assessment	The regular collection, analysis and sharing of information about health conditions, risks, and resources in a community. The assessment function is needed to identify trends in illness, injury, and death, the factors which may cause these events, available health resources and their application, unmet needs, and community perceptions about health issues.
Assignment	Process under which Medicare pays its share of the allowed charge directly to the physician or supplier. Medicare will do this only if the physician accepts Medicare's allowed charge as payment in full (guarantees not to balance bill). Medicare provides other incentives to physicians who accept assignment for all patients under the Participating Physician and Supplier Program.
Assignment of Benefits	Method used when a claimant directs that payment be made directly to the health care provider by the health plan.
Assisted Living Facility	Independent living facilities that provide on-site services like meals, supervision, and assistance with activities of daily living (ADL's).
Autoassignment	A term used with Medicaid mandatory managed care enrollment plans. Medicaid recipients who do not specify their choice for a contracted plan within a specified time frame are assigned to a plan by the state.
Average Length of Stay (ALOS)	Refers to the average length of stay per inpatient hospital visit. Figure is typically calculated for both commercial and Medicare patient populations.
Average Wholesale Price (AWP)	Commonly used in pharmacy contracting, the AWP is generally determined through reference to a common source of information. Average cost of a non-discounted item to a pharmacy provider by wholesale providers.

Balance Billing	Physician charges in excess of Medicare-allowed amounts, for which Medicare patients are responsible, subject to a limit. In Medicare and private fee-for-service health insurance, the practice of billing patients in excess of the amount approved by the health plan (a balance bill cannot exceed 15% of the allowed charge for nonparticipating physicians).
Basic DRG Payment Rate	Payment rate a hospital will receive for a Medicare patient in a particular diagnosis-related group. Payment rate is calculated by adjusting standardized amount to reflect wage rates in hospital's geographic area (and cost of living differences unrelated to wages) and costliness of the DRG.
Behavioral Risk Factor Surveillance System (BRFSS)	BRFSS is an annual telephone survey conducted by the Centers for Disease Control and Prevention of state residents aged 18 and over that measures a variety of behaviors that affect health, such as diet, smoking, and use of preventive health services.
Beneficiary	Someone who is eligible for or receiving benefits under an insurance policy or plan. The term is commonly applied to people receiving benefits under the Medicare or Medicaid programs.
Beneficiary Liability	The amount beneficiaries must pay providers for Medicare-covered services. Liabilities include copayments, and coinsurance amounts, deductibles, and balance billing amounts.
Benefit Eligibility Triggers	Defines the requirements in order for an insurance company to consider a claim. Most often it is the inability to perform a specific number of Activities of Daily Living (ADLs) and/or impairment of a cognitive ability such as Alzheimer's.
Benefit Package	Services covered by a health insurance plan and the financial terms of such coverage, including cost sharing and limitations on amounts of services.
Benefits-to-Costs Ratio (Evaluation)	The total discounted benefits divided by the total discounted costs.
Budget Neutrality	Budget neutrality is a limitation imposed on an overall budget to ensure that it will neither increase nor decrease the total amount of the previous budget. For example, 1115 waivers are only granted if states can prove budget neutrality.
Bundled Payment	A single comprehensive payment for a group of related services.
Bundled Service	A "bundled service" combines closely-related specialty and ancillary services for an enrolled group or insured population by a group of associated providers.
Bundling	The use of a single payment for a group of related services.
Buy-In	Procedure whereby states pay a monthly premium to the Social Security Administration on behalf of Medicaid Recipients, who they are required or choose to cover, enrolling them in Medicare Title XVIII Part A and Part B program.
Capital Costs	Depreciation, interest, leases and rentals, and taxes and insurance on tangible assets like physical plant and equipment.
Capitation	A health insurance payment mechanism which pays a fixed amount of money per person to cover services, without regard to the actual number or nature of services provided to each person in a set period of time. The provider is financially responsible for coordinating patient care within the fees or capitated rate for all patients.
Capitation Payments	Monthly payments made to managed care organization, based on per member per month rates regardless of member utilization.
Care Management	A licensed care manager that will assess your condition, create a plan of care along with your physician, coordinate and monitor ongoing care needs. Typically this is a licensed registered nurse.
Carve-Out Service	A "carve-out" is typically a service provided within a standard benefit package but delivered exclusively by a designated provider or group.
Case Management	Monitoring & coordinating delivery of health services for individual patients to enhance care & manage costs; often used for patients with specific diagnoses or who require high-cost or extensive health care services.
Case Mix	The mix of patients treated within a particular institutional setting, such as the hospital. Patient classification systems like DRGs can be used to measure hospital case mix.

Case-Mix Index (CMI)	The average DRG weight for all cases paid under PPS. The CMI is a measure of the relative costliness of the patients treated in each hospital or group of hospitals. See also DRG. (MedPAC, 1998)
Catastrophic Health Insurance	Health insurance which provides coverage for treating severe or lengthy illnesses or disability. Generally these policies cover all, or a specified percentage of, medical expenses above an amount that is the responsibility or another insurance policy up to a maximum limit of liability.
Categorically Needy	Individuals who meet the technical eligibility requirements (aged, blind, or disabled) and financial eligibility requirements of the SSI program and those who meet the technical eligibility requirements (a member of a family with children deprived of support of at least one patient) and financial eligibility requirements of the AFDC program.
Centers for Disease Control and Prevention (CDC)	A division of the U.S. Public Health Service which is responsible for analyzing and fighting infectious diseases as well as responding to public health emergencies.
Centers for Medicare & Medicaid Services (CMS)	The federal government agency within the Department of Health and Human Services which directs the Medicare, Medicaid, and CHIP programs, (Titles XVIII, XIX, and XXI of the Social Security Act) conducts research to support these programs and oversees more than a quarter of all health care costs in the United States. Prior to June 14, 2001, known as the Health Care Financing Administration (HCFA)
Civilian Health & Medical Program of the Uniformed Services (CHAMPUS)	A health plan that serves the dependents of active duty military personnel and retired military personnel and their dependents.
Children's Health Insurance Program (CHIP)	Federal program initiated in 1998, and jointly funded by states and the federal government, which provides medical insurance coverage for children not covered by state Medicaid-funded programs.
Chronic Care	Care and treatment rendered to individuals whose health problems are of a long-term and continuing nature. Chronic care facilities include nursing homes, mental hospitals and rehabilitation facilities.
Claim	A request for payment filed with the Contractor, on a form or electronic format prescribed by DMS and the Contractor, by a Medicaid provider for Medicaid-covered medical and medically related services provided on behalf of an eligible Medicaid recipient.
Claim Audit	The process by which a current claim is checked against paid claims history for duplications, relationships, or limitations.
Claim Type	The classification of claims by origin or type of service provided to a recipient.
Clinical Preventive Services	Health care services delivered to individuals in clinical settings for the purpose of preventing the onset or progression of a health condition or illness.
Cognitive Impairment	Mental deterioration caused by Alzheimer's disease or other forms of dementia.
Coinsurance	A type of cost sharing where the insured party and insurer share payment of the approved charge for covered services in a specified ratio after payment of the deductible by the insured. For example, for Medicare physicians' services, the beneficiary pays coinsurance of 20% of allowed charges while Medicare pays 80%.
Competitive Medical Plan (CMP)	A health plan that is eligible for a Medicare risk contract (although it is not a federally qualified HMO) because it meets specified requirements for service provision, payment, and financial solvency. See Federally Qualified HMO.
Composite Rate	Payment by Medicare that covers the bundle of services, tests, drugs, and supplies routinely required for dialysis treatment.
Comprehensive Policy	Most popular Long Term Care plan design. This policy pays for long-term care at home, in a residential assisted living facility, as well as in a nursing home.
Congregate Facilities	Retirement apartments where housekeeping, meals, laundry and other amenities are available.
Consolidated Omnibus Budget Reconciliation Act	COBRA is a federal law that allows and requires past employees to be covered under company health insurance plans for a set premium. This program gives

(COBRA)	individuals the opportunity to remain insured when their current plan or position has been terminated.
Consumer Assistance Program	A program that exists in some states to help people when they have problems or questions about managed care. A consumer assistance program can help you make decisions about the health plan or provider that is best for you (when you have a choice). Consumer assistance programs are also set-up to help people resolve problems they experience with their provider or health plan. Consumer assistance programs are sometimes called *ombudsprograms*.
Consumer Price Index (CPI)	CPI is prepared by the U.S. Bureau of Labor Statistics. It is a monthly measure of the average change in the prices paid by urban consumers for a fixed market basket of goods and services. The medical care component of CPI shows trends in medical care prices based on specific indicators of hospital, medical, dental, and drug prices.
Continuing Care Retirement Facilities	A facility where residents own their housing unit and pay a large one-time entry free plus a monthly maintenance fee in exchange for assurance of lifetime long-term care.
Conversion Factor	The multiplicative factor used to translate relative value units into dollar amounts for physician payments under a fee schedule.
Conversion Factor Update	Annual percentage change to the conversion factor. For Medicare, the update is set by a formula to reflect medical inflation, changes in enrollment, growth in the economy, and changes in spending due to other changes in law.
Coordination of Benefits (COB)	A provision in an insurance plan wherein a person covered under more than one group plan, has benefits coordinated such that all payments are limited to 100% of the actual charge or allowance. Most plans also specify rules whereby one insurer is considered primary and the other is considered secondary.
Copayment	A copayment is a cost-sharing arrangement in which a member pays a specified charge for a specified service (e.g., $10 for an office visit). The member is usually responsible for payment at the time the service is rendered.
Corrective Action Plan	Upon missing a deadline or milestone, the contractor or agency missing his/her target entity may be required to develop a written "corrective action" plan to document the steps to correct the deficiency and prevent a recurrence.
Cost Containment	Control or reduction of inefficiencies in the consumption, allocation, or production of health care services that contribute to higher than necessary costs. (Inefficiencies in consumption can occur when health services are inappropriately utilized; inefficiencies in allocation exist when health services could be delivered in less costly settings without loss of quality; and, inefficiencies in production exist when the costs of producing health services could be reduced by using a different combination of resources.)
Cost Contract	An arrangement between a managed health care plan & HCFA under Section 1876 or 1833 of the Social Security Act, under which the health plan provides health services and is reimbursed its costs. The beneficiary can use providers outside the plan's provider network.
Cost Sharing	Cost-sharing is a general term referring to payments made by health insurance enrollees for covered services. Examples of cost sharing include deductibles, coinsurance, and copayments.
Cost Shifting	The condition which occurs when health care providers pass costs for health services one group does not pay to other groups. When health care providers are not reimbursed or not fully reimbursed for providing health care, usually to uninsured or Medicare patients, charges to those who do pay are increased. Employer and insurer discounts on fees, care for the uninsured and government rate-setting contribute to cost shifting.
Cost/Benefit Analysis	Analytical procedure for determining the economic efficiency of a program, expressed as the relationship between costs and outcomes, usually measured in monetary terms.

Covered Service	This means a service provided by a Medicaid provider for a Medicaid recipient for which payment is available under the Indiana Medicaid program subject to the limitations of this article.
Crossover Claim	A claim submitted by a Medicare/Medicaid provider to a Medicare carrier or intermediary on behalf of a dual Medicare/Medicaid eligible or Qualified Medicare Beneficiary that has been paid by Medicare and crossed over to Medicaid for payment of the Medicare deductible and/or coinsurance.
Crowd Out	Crowd-out, also called substitution, is a phenomenon whereby new public programs or expansions of existing public programs designed to extend coverage to the uninsured prompt some privately insured persons to drop their private coverage and take advantage of the expanded public subsidy.
Culturally Competent Care	Medical treatment explicitly designed to address and respect different cultural customs and norms.
Current Population Survey (CPS)	CPS is a U.S. Census Bureau survey conducted nationally to measure employment, health insurance status, income, and other variables. Results from this survey are used in many states to estimate the size and composition of populations that are potentially eligible for public programs and the number of persons without health insurance.
Current Procedural Terminology (CPT)	The coding system for physicians' services developed by the CPT Editorial Panel of the American Medical Association; basis of the HCFA Common Procedure Coding System. (MedPAC, 1998)
Customary Charge	One of the screens previously used to determine a physician's payment for a service under Medicare's customary, prevailing, and reasonable payment system. Customary charges were calculated as the physician's median charge for a given service over a prior 12-month period.
Customary, Prevailing, and Reasonable (CPR)	The method of paying physicians under Medicare from 1965 until implementation of the Medicare Fee Schedule in January 1992. Payment for a service was limited to the lowest of: (1) physician's billed charge for the service, (2) physician's customary charge for the service, or (3) prevailing charge for that service in the community.
Deductible	A deductible is a specified amount of money a member must pay before insurance benefits begin. The deductible is usually expressed in terms of an annual amount.
Defense Eligibility Enrollment Reporting System (DEERS)	A federal data exchange which provides information on military employees health insurance benefits.
Defensive Medicine	Physician practices just to reduce risk of a liability claim, e.g., performing diagnostic tests of marginal value. Defensive medicine totals an estimated $20.7 billion. (AMA, 1993)
Defined Contribution Coverage	A funding mechanism for health benefits whereby employers make a specific dollar contribution toward the cost of insurance coverage for employees, but make no promises about specific benefits to be covered.
Deliverables	Documents or tasks specified in a contract or other binding document which must be completed/delivered within given timeframes.
Denied Claim	A claim for which no payment is made to the provider because the claim is for non-covered services, an ineligible provider or recipient, or is a duplicate of another transaction, or has failed to pass a significant requirement in the claims processing system.
Diagnosis (Dx)	The provider's determination of a patient's condition, sign, or symptom, using the ICD-9-CM coding system.
Diagnosis Related Group (DRG)	A system used for payment under Medicare's PPS and by some other payers. The DRG system classifies patients into groups based on the principal diagnosis, type of surgical procedure, presence or absence of significant co-morbidities or complications, and other relevant criteria. DRGs are intended to categorize patients into groups that are clinically meaningful and homogeneous with respect to resource use. Medicare's prospective payment system (PPS) currently uses

	almost 500 mutually exclusive DRGs, each of which is assigned a relative weight that compares its costliness to the average for all DRGs.
Direct Contracting	Direct contracting usually refers to a service (e.g. substance abuse treatment) that an employer contracts directly to save money on its employees' health plan, leaving employees free to choose among other eligible providers for their primary, obstetric, pediatric and other medical care needs.
Disaster Recovery Plan	A plan to ensure continued claims processing through adequate alternate facilities, equipment, back-up files, documentation and procedures in the event that the primary processing site is lost to the contractor.
Disproportionate Share Hospital (DSH) Adjustment	A DSH adjustment is a payment adjustment under Medicare's Prospective Payment System (PPS) or under Medicaid for hospitals that serve a relatively large volume of low-income patients.
Do-Not-Resuscitate (DNR) Order	A doctor's written instructions not to attempt cardiopulmonary resuscitation (CPR) in the event of cardiac or respiratory arrest. The DNR order is attached to a person's medical chart like any other medical order, and may be filed at hospitals, in private practice, with local emergency services, and with companies such as MedicAlert (which provides a bracelet to wear).
Drug File Updating Service	A service which provides information and periodic updates to the insurance industry, drug companies, and governmental agencies which includes drug prices, NDC numbers, federal upper limits and other data.
Dual Eligibles	A Medicare beneficiary who also receives the full range of Medicaid benefits offered in his or her state.
Durable Medical Equipment (DME)	DME is any medical equipment that can usually withstand repeated use, is useable at home, and is not beneficial to a person without an illness or injury. Splinting, orthopedic bracing, and wheelchairs are good examples of DME.
Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)	A program mandated by law as part of the Medicaid program. The law requires that all states have in effect a program for eligible children under age 21 to receive a medical assessment, and health care treatments and other measures to correct any defects and chronic conditions discovered.
Edit/Audit File	An on-line inquiry file which maintains information on all edits and audits used by the system.
Eldercare Law	A specialized practice of law that deals with the rights and issues of health, finances, and the well-being of the elderly. Issues which are addressed include social security, nursing home arrangements, pensions, and housing disputes.
Electronic Claims Management	A system which not only captures claims over telephone lines, facilitated by networks, but also adjudicates the claims submitted by the provider on-line and in real time.
Emergency Medical Services (EMS)	Services utilized in responding to the perceived individual need for immediate treatment for medical, physiological, or psychological illness or injury.
Employee Retirement Income Security Act (ERISA)	ERISA is a federal law passed in 1974 that established new standards and reporting/disclosure requirements for employer-funded pensions and health benefit programs. ERISA exempts self-insured health plans from state laws governing health insurance, including contribution to risk pools, prohibitions against disease discrimination, and other state health reforms.
Employer-Sponsored Insurance (ESI) Buy-*I*n	A buy-in to employer-sponsored insurance is a program in which Medicaid or SCHIP pays premiums for employer-based health insurance to cover recipients when it is determined that buying the private insurance plan is cost-effective in comparison to the cost of covering the enrollee in the default program.
Encounter Data	Description of the diagnosis made and services provided when a patient visits a health care provider under a managed-care plan. Encounter data provide much of the same information available on the bills submitted by fee-for-service providers.
Enrollment	The process by which providers are accepted by the Department for Medicaid Services as eligible to receive reimbursement.

Exclusive Provider Organizations (EPO)/ exceptions	An indemnity or service plan that provides benefits only if care is rendered by the institutional and professional providers with which it contracts, with some
Exclusive Provider Arrangement (EPA)	for emergency and out-of-area services.
Experience Rating	A system used by insurers to set premium levels based on the insured's past loss experience. For example, rating may be based on service utilization for health insurance or on liability experience for professional liability insurance.
Explanation of Benefits (EOB)	A form received from the insurer which explains benefits that were paid and/or charges that were rejected.
Explanation of Benefits File	An on-line inquiry file which maintains the codes and the messages which print on system reports and remittance advices.
Extended Care Facility	Is a skilled nursing facility that provides post-hospital services to be reimbursable by Medicare.
Family Coverage	Family coverage is the concept of covering not only eligible children through public programs, i.e. Medicaid or SCHIP, but also their parents. For example, in the SCHIP program, states may receive CMS approval to cover eligible children and their parents through employer-sponsored insurance. In order to receive CMS approval to provide family coverage, programs must be cost-effective and must not cause crowd-out.
Federal Employee Health Benefit Program (FEP)	Health insurance program for Federal workers and their dependents.
Federal Employees Health Benefits Program (FEHBP) -	The group health insurance plan for all Federal employees established in 1959 under the Federal Employees Health Benefits Act. Federal employees may choose to participate in one of two plans: a service benefit plan administered by Blue Cross and Blue Shield, or an indemnity plan offered by the insurance industry through the Aetna Life Insurance Company.
Federal Financial Participation (FFP)	A percent of state expenditures to be reimbursed by the federal government for the medical assistance benefit costs an for the administrative cost of the Medicaid program.
Federal Fiscal Year (FFY)	The federal government’s year for doing business, October 1 - September 30.
Federal Poverty Level (FPL)	The Federal Poverty Level is the amount of income determined by the Department of Health and Human Services to provide a bare minimum for food, clothing, transportation, shelter, and other necessities. The level varies according to family size and changes yearly. Public assistance programs, such as Medicaid and SCHIP, usually define income limits in relation to FPL.
Federally Qualified Health Center (FQHC)	FQHC is a federal payment option that enables qualified providers in medically underserved areas to receive cost-based Medicare and Medicaid reimbursement and allows for the direct reimbursement of nurse practitioners, physician assistants and certified nurse midwives. Federal legislation creating the FQHC category was enacted in 1989.
Federally Qualified HMO	An HMO that has satisfied certain federal qualifications pertaining to organizational structure, provider contracts, health service delivery information, utilization review/quality assurance, grievance procedures, financial status, and marketing information as specified in Title XIII of the Public Health Service Act.
Fee Schedule	A list of predetermined payment rates for medical services. See Medicare Fee Schedule.
Fee Schedule Payment Area	A geographic area within which payment for a given service under the Medicare Fee Schedule does not vary. See Geographic Adjustment Factor.
Fee-For-Service	A method of paying health care providers for individual medical services rendered, as opposed to paying them salaries or capitated payments. physicians. It is reimbursing the provider whatever fee he or she charges on completion of a specific service.
Fiscal Agent	A contractor who processes Medicaid provider claims for payments and performs certain other related functions as an agent for the Commonwealth.

Five-Year Review	A review of the accuracy of Medicare's relative value scale that the Health Care Financing Administration is required to conduct every five years.
Formulary	A list of approved drugs that a health plan maintains. If your provider prescribes a drug that is not on the list, you should ask your provider if there is an equally effective alternative on the formulary. If no equally effective drug is available, you should ask your provider to request a special exception for you. Often, if your provider can provide the health plan with information why it is necessary for you to receive a specific prescription medication, they will make an exception for you.
Full Cost Buy-In	A full cost buy-in, in relation to public insurance programs, is an unsubsidized health insurance program. These state programs allow people who do not meet the income requirements for their Medicaid or SCHIP plans, to enroll in the state plan by paying the full premium.
Gatekeeper	The person in a managed care organization who decides whether or not a patient will be referred to a specialist for further care. Physicians, nurses and physician assistants all function as gatekeepers.
Generalists	Physicians who are distinguished by their training as not limiting their practice by health condition or organ system, who provide comprehensive and continuous services, and who make decisions about treatment for patients presenting with undifferentiated symptoms. Typically include family practitioners, general internists, and general pediatricians.
Geographic Adjustment Factor (GAF)	The GAF for each service in a particular payment area is the average of the area's three geographic practice cost indexes weighted by the share of the service's total RVUs accounted for by the work, practice expense, and malpractice expense components of the Medicare Fee Schedule.
Geographic Practice Cost Index (GPCI)	An index summarizing the prices of resources required to provide physicians' services in each payment area relative to national average prices. There is a GPCI for each component of the Medicare Fee Schedule: physician work, practice expense, and malpractice expense. The indexes are used to adjust relative value units to determine the correct payment in each fee schedule payment area.
Global Budgeting	A method of hospital cost containment in which participating hospitals share a budget, setting the maximum amount of money that will be paid for health care. This can be done on a national or state level. Methods for allocating funds among hospitals may vary but the key is that participating hospitals agree to an aggregate cap on revenues that they will receive each year.
Grievance	A formal complaint that you can file with your health plan when you have a problem with your provider or experience problems in getting health care services you need. In Medicaid, if Member Services does not resolve your problem to your satisfaction, you can pursue a grievance with the state Medicaid program. If you aren't in Medicaid, but have another type of insurance, there may be state laws that allow you a right to file an external appeal to have your grievance considered by an independent third-party who is not affiliated with your health plan.
HCPCS (HCFA Common Procedure Coding System)	A Medicare coding system, designed by HCFA, based on the American Medical Association's Current Procedural Terminology (CPT), expanded to accommodate additional services covered by Medicare. It is a three-level coding system, consisting of: CPT, National or Level 2, and Local or Level 3 codes. It describes the physician and non-physician patient services covered by Medicaid and Medicare Programs and is used primarily to report reimbursable services provided to the patients.
Health Care Financing Administration (HCFA)	The federal government agency within the Department of Health and Human Services which directs the Medicare and Medicaid programs, (Titles XVIII and XIX of the Social Security Act) conducts research to support these programs and oversees more than a quarter of all health care costs in the United States. Effective June 14, 2001, HCFA's name was changed to the Centers for Medicare and Medicaid Services (CMS).
Health Care Prepayment Plan (HCPP)	Plans that receive payment for their reasonable costs of providing Medicare Part B services to Medicare enrollees.

Health Employer Data and Information Set (HEDIS)	A set of performance measures for health plans developed for the National Committee for Quality Assurance (NCQA) that provides purchasers with information on effectiveness of care, plan finances and costs, and other measures of plan performance and quality. HEDIS allows comparisons between plans on quality, access and patient satisfaction, membership and utilization, financial information, and health plan management. HEDIS was developed by employers, HMOs, and the National Committee for Quality Assurance.
Health Insurance Claim (HIC) Number	An individual's Social Security Number with a suffix, which the Medicare program uses for an individual's identification number.
Health Insurance Portability and Accountability Act continuation (HIPAA) of 1996	HIPAA is a federal act that protects people who change jobs, are self-employed, or who have pre-existing medical conditions. It standardizes approachs to of healthcare benefits for individuals and members of small group health plans and establishes parity between benefits extended to these individuals and benefits offered to employees in large group plans. The act also contains provisions designed to ensure that prospective or current enrollees in a group health plan are not discriminated against based on health status as well as significant provisions intended to safeguard protected health information (PHI).
Health Insurance Premium Payment (HIPP) Program	The Health Insurance Premium Payment program is a Medicaid program that pays for health insurance for Medicaid eligible persons with access to employer based insurance when it is proven cost effective to do so.
Health Insurance Purchasing Cooperatives (HIPCs)	Public or private organizations which work to secure health insurance coverage for certain populations of people. The goal is to consolidate purchasing responsibilities to obtain greater leverage with insurers in order to reduce administrative costs of buying, selling and managing insurance policies. This is done by combining everyone in a specific geographic region and basing insurance rates on the people in that area. Private cooperatives are usually voluntary associations of employers in a geographic region who band together to purchase insurance for their employees. Public cooperatives are established by state governments to purchase insurance for public employees and Medicaid beneficiaries.
Health Maintenance Organization (HMO)	A managed care plan that integrates financing and delivery of a comprehensive set of health care services to an enrolled population. HMOs may contract with, directly employ, or own participating health care providers. Enrollees are usually required to choose from among these providers and in return have limited copayments. Providers may be paid through capitation, salary, per diem, or pre-negotiated fee-for-service rates.
Health Network	General term for a managed care program that operates a network of participating providers.
Health Professional Shortage Area (HPSA)	An urban or rural geographic area, a population group, or a public or nonprofit private medical facility that the Secretary of the federal Department for Health and Human Services determines to be served by too few health professionals. Physicians who provide services in HPSAs qualify for the Medicare bonus payment.
High Risk Pool	A high-risk pool is, typically, a state-created, nonprofit association that offers comprehensive health insurance benefits to individuals with pre-existing health problems: people who have been denied coverage in the private market due to a chronic illness or condition; who have found they can only access restricted coverage; or have found coverage that costs more than what is available from the pool. Funding for the pool is subsidized through assessments on insurers or through government revenues.
Home Health Care	Skilled nursing or other professional services/therapies in your residence.
Homemaker Services	Housekeeping, cooking and grocery shopping.
Hospice	A form of palliative care in which the main focus is on comfort, rather than cure. Generally, people in hospice care have elected to forego curative treatments, and often enroll when they have a life expectancy of less than six months. In the U.S.,

	hospice care often takes place in a patient's home. Support for people with terminal illness.
Hospital Outshopping	The bypassing of local hospitals by patients in favor of other hospitals (usually because the patients believe the quality of care is better in the other hospital).
ICD-9-CM (International Classification of Diseases , Ninth Revision, Clinical Modification)	Refers to the International Classification of Diseases, 9th Revision, Clinical Modification. A diagnosis and procedure classification system designed to facilitate collection of uniform and comparable health information. This system is used to group patients into DRGs. The coding and terminology provide a uniform language that will accurately designate primary and secondary diagnosis and provide for reliable, consistent communication on claim forms.
Income Disregards	Income disregards, in relation to state health insurance programs, are certain amounts of income deducted in counting allowable income for eligibility for a certain program, such as Medicaid or SCHIP.
Independent Living	Senior retirement dwellings with no built-in services.
Indigent Care	Care provided at no cost to people that are medically indigent, meaning they do not have health insurance or are not covered by Medicare, Medicaid, or other public programs. This does not necessarily refer to people who are indigent or homeless.
Indirect Medical Education (IME) Adjustment	A payment adjustment applied to DRG and outlier payments under PPS for hospitals that operate an approved graduate medical education program. For operating costs, the adjustment is based on the hospitals' ratio of the number of interns and residents to the number of beds. For capital costs, it is based on the hospital's ratio of interns and residents to average daily occupancy. (HCFA)
Integrated Provider (IP)	A group of providers that offer comprehensive and coordinated care. These groups usually provide a range of medical care facilities and service plans including hospitals, group practices, a health plan and other related health care services.
Integrated Service Networks (ISNs)	Integrated Service Networks are organizations that are accountable for the costs and outcomes associated with delivering a full continuum of health care services to a defined population. Under an ISN arrangement, a network of hospitals, physicians, and other health care providers furnish all needed health services for a fixed payment.
Intensive Care Unit (ICU)	A specialized part of the hospital designed for care of the critically ill whose conditions necessitate constant monitoring.
Intermediate Care Facility (ICF)	Provides mainly maintenance services in such facilities such as homes for the aged and rest homes.
Job-Lock	The inability of individuals to change jobs because they would lose crucial health benefits. (AMA, 1993)
Joint Commission on the Accreditation of Health Care Organizations (JCAHO)	A national private, non-profit organization that accredits health care organizations and agencies and establishes guidelines of operation for these facilities.
Length of Stay (LOS)	This is the length or number of days that an individual stay in an inpatient setting.
Level of Care	In a inpatient hospital setting, this means the reimbursement methodology used to pay providers for the services rendered, including DRG, psychiatric, rehabilitation, and burn.
Limited Service Hospital	A hospital, often located in rural areas, that provides a limited set of medical and surgical services.
Limiting Charge	The maximum amount that a nonparticipating physician is permitted to charge a Medicare beneficiary for a service; in effect, a limit on balance billing. Starting in 1993 the limiting charge has been set at 115% of the Medicare-allowed charge.
Living Will	A legal document stating the preferences of an individual about his or her preferences for future medical treatment in case he or she cannot make competent decisions at a later date.
Local Area Network (LAN)	A network linking personal computers at the DMS among themselves, other state agencies, and with the fiscal agent on-line system.
Lock-In	The restriction of a Medicaid recipient to a particular provider as determined by the state.

Long Term Care (LTC)	Health care, personal care and social services provided to people who have lost, or never acquired, some degree of functional capacity. This care can take place in an institution or at home, on a long-term basis. These conditions often exist with the chronically ill, aged, disabled, or retarded. Services can include informal services provided by family or friends as well as formal services provided by professionals or agencies.
Long Term Care Insurance	A type of insurance designed to reimburse you or pay directly your medical expenses when you need assistance with the acts of daily living. This insurance pays for care which your regular health insurance does not.
Major Teaching Hospitals	Hospitals with an approved graduate medical education program and a ratio of interns and residents to beds of 0.25 or greater. (HCFA)
Malpractice Expense	The cost of professional liability insurance incurred by physicians. A component of the Medicare relative value scale.
Managed Care	Any system of health payment or delivery arrangements where the health plan attempts to control or coordinate use of health services by its enrolled members in order to contain health expenditures, improve quality, or both. Arrangements often involve a defined delivery system of providers with some form of contractual arrangement with the plan.
Managed Care Organization (MCO)	Risk-bearing entities providing physical or behavioral health services through networks of providers, on a prepaid capitated basis.
Market Basket Index	An index of the annual change in the prices of goods and services providers used to produce health services. There are separate market baskets for PPS hospital operating inputs and capital inputs; and SNF, home health agency and renal dialysis facility operating and capital inputs.
Mass Adjustments	The systematic adjustment of more than one claim at the same time for the same reason.
Means Test	A test in which an individuals or family's income or assets are evaluated in order to determine if that individual or family is eligible for public support, such as Medicaid.
Medicaid (Title XIX)	Medicaid is an entitlement program, established under Title XIX of the Social Security Act of 1935, financed by both the state and federal government (through the Social Security Administration) and managed by the states. Medicaid provides health care insurance to eligible persons younger than 65 years of age who cannot afford to pay private health insurance. The federal government matches the states' contribution on a certain minimal level of available coverage. The states may institute additional services, but at their own expense.
Medical Expenditure Panel Survey (MEPS)	MEPS is a nationally representative survey of health care use, expenditures, sources of payment, and insurance coverage for the U.S. civilian non-institutionalized population, as well as a national survey of nursing homes and their residents. MEPS is co-sponsored by the Agency for Health Care Research and Quality (AHRQ) and the National Center for Health Statistics (NCHS). This survey is designed to yield comprehensive data that estimate the level and distribution of health care use and expenditures, monitor the dynamics of the health care delivery and insurance systems, and assess health care policy implications.
Medical Group	An affiliation of a large group of health care providers that markets the services of its providers collectively and which contracts with health plans to accept patients on a capitated basis. Because medical groups generally refer patients to specialists within their own group, in some ways medical groups take on characteristics of a health plan.
Medical IRAs	Personal accounts which, like individual retirement plans, allow a person to accumulate funds for future use, but stipulate that those funds be used solely to pay for medical services. After setting up such an account, an individual decides how much money he or she will spend on health care, and therefore assumes much of the responsibility for insurance decisions that normally would fall to the employer.
Medical Savings Account (MSA)	A medical savings account is a consumer-contributed, tax-deferred account to be used for future medical expenses. The plan encourages patients to accept more responsibility for medical expenses and use of health care resources by

	contributing a certain amount of money per year. Rules for proposed MSAs include: (1) such accounts may be established only if the consumer has no insurance other than catastrophic coverage, usually with high deductibles; (2) there is a limit to the amount that may be contributed to an MSA and excluded or deducted from gross income; (3) funds drawn from an MSA to cover health care costs are excludable from gross income, but funds used for nonmedical purposes would be taxed as ordinary income with an additional penalty. The medical savings account pilot project was established through the Health Insurance Portability and Accountability Act of 1996.
Medically Indigent	A term used in the medical industry to describe a person who does not have insurance and is not covered by Medicaid, Medicare or other public programs.
Medicare	A federal health insurance program administered by the Health Care Financing Administration (HCFA) for people 65 years or older, certain people with disabilities under 65 years of age, and people with people with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant). Medicare has two parts: Part A, which is hospital insurance, and Part B, which is medical insurance.
Medicare - Part A	Medical Hospital Insurance (HI) under Part A of Title XVIII of the Social Security Act, which covers beneficiaries for inpatient hospital, home health, hospice, and limited skilled nursing facility services. Beneficiaries are responsible for deductibles and copayments. Part A services are financed by the Medicare HI Trust Fund, which consists of Medicare tax payments.
Medicare - Part B	Medicare Supplementary Medical Insurance (SMI) under Part B of Title XVII of the Social Security Act, which covers Medicare beneficiaries for physician services, medical supplies, and other outpatient treatment. Beneficiaries are responsible for monthly premiums, copayments, deductibles, and balance billing. Part B services are financed by a combination of enrollee premiums and general tax revenues.
Medicare Assignment	An agreement in advance by a physician to accept Medicare's Allowed charge as payment in full (guarantees not to balance bill). Medicare pays its share of allowed charge directly to physicians who accept assignment and provides other incentives under the Participating Physician and Supplier Program.
Medicare Choices Demonstration	A demonstration project designed to offer flexibility in contracting requirements and payment methods for Medicare's managed-care program. Participating plans include PSOs and PPOs. Plans are required to submit encounter data to HCFA, and most will test new risk-adjustment methods.
Medicare Cost Contract	A contract between Medicare and a health plan under which the plan is paid on the basis of reasonable costs to provide some or all of Medicare-covered services for enrollees.
Medicare Cost Report (MCR)	An annual report required of all institutions participating in the Medicare program. The MCR records each institution's total costs and charges associated with providing services to all patients, the portion of those costs and charges allocated to Medicare patients, and the Medicare payments received.
Medicare Current Beneficiary Survey (MCBS)	A longitudinal survey administered by HCFA that provides information on specific aspects of beneficiary access, utilization of services, expenditures, health insurance coverage, satisfaction with care, health status and physical functioning, and demographic information.
Medicare Economic Index (MEI)	An index that tracks changes over time in physician practice costs. From 1975 through 1991, increases in prevailing charge screens were limited to increases in the MEI.
Medicare Provider Analysis and Review (MedPAR) File	A HCFA data file that contains charge data and clinical characteristics, such as diagnoses and procedures, for every hospital inpatient bill submitted to Medicare for payment.
Medicare Risk Contract	A contract between Medicare and a health plan under which the plan receives monthly capitated payments to provide Medicare-covered services for enrollees, and thereby assumes insurance risk for those enrollees. A plan is eligible for a risk contract if it is a federally qualified HMO or a competitive medical plan.

Medicare SELECT	A form of Medigap insurance that allows insurers to experiment with the provision of supplemental benefits through a network of providers. Coverage of supplemental benefits is often limited to those services furnished by participating network providers and emergency, out-of-area care.
Medicare+Choice	A program created by the Balanced Budget Act of 1997 to replace the existing system of Medicare risk and cost contracts. Beneficiaries will have the choice during an open season each year to enroll in a Medicare+Choice plan or to remain in traditional Medicare. Medicare+Choice plans may include coordinated care plans (HMOs, PPOs, or plans offered by provider -sponsored organizations); private fee-for-service plans; or plans with medical savings accounts.
Medigap Insurance	Privately purchased insurance policy that supplements Medicare coverage and meets specified requirements set by Federal statute and the National Association of Insurance Commissioners. Benefits may include payment of Medicare deductibles, coinsurance and balance bills, as well as payment for services not covered by Medicare. Medigap has ten standard plans called Plan "A" through Plan "J," each with a different set of benefits. Medigap insurance must conform to one of ten federally standardized benefit packages. Medigap policies vary by state.
Megan's Law	Law requiring that information regarding a sexual predator or person convicted of sexual crimes be provided to the public.
Milestone	The measuring point used to review and approve progress, to authorized continuation of work, and, depending on the terms of the contract, to pay for work completed.
Morbidity	A measure of disease incidence or prevalence in a given population, location, or other grouping of interest.
Mortality	A measure of deaths in a given population, location, or other grouping of interest.
Multiple Employer Trust (MET)	A group of small employers brought together by a plan sponsor to provide group health coverage to their employees either through insurance or self-funding.
National Claims History (NCH) System	A HCFA data reporting system that combines both Part A and Part B claims in a common file. The National Claims History system became fully operational in 1991.
National Committee for Quality Assurance (NCQA)	A national organization, private, not-for-profit, representing consumers, purchasers and providers of managed health care, which reviews and accredits quality assurance programs in the managed care industry with the goal of enabling purchasers and consumers of managed health care to distinguish among plans based on quality.
National Health Interview Survey (NHIS)	NHIS is a survey conducted by the National Center for Health Statistics (NCHS) to collect health-related information, such as illness and injury recall, health conditions and related disabilities, hospitalization, and physician visits, from a sampling of American households.
National Practitioner Data Bank	A computerized data bank maintained by the federal government that contains information on physicians against whom malpractice claims have been paid or certain disciplinary actions have been taken.
National Survey of America's Families (NSAF)	NSAF provides a comprehensive look at the well-being of adults and children. The survey oversamples low-income families, looking at important aspects about their lives and how they differ from the lives of children and adults in families with higher incomes. NSAF is conducted in 13 states: Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin.
Non-Participating Physician	A physician who does not sign a participation agreement and, therefore, is not obligated to accept assignment on all Medicare claims.
Non-Physician Practitioner	A health care professional who is not a physician. Examples include Advanced Registered Nurse Practitioners (ARNP) and Physician Assistants (PA).
Nursing Facility (NF)	An institution that provides skilled nursing care (SNF) and rehabilitation services to injured, functionally disabled, or sick persons. Formerly, distinctions were made between intermediate care facilities (ICFs) and skilled nursing facilities (SNFs). The Omnibus Budget Reconciliation Act of 1987 eliminated this distinction effective

	October 1, 1990, by requiring all nursing facilities to meet SNF certification requirements.
Ombudsprogram	See Consumer Assistance Program.
On-Line	Interaction between a user operating a CRT, personal computer, or point of service (POS) device to send and receive information on a video display via a telecommunications network to another computer.
Outliers	Cases with extremely long lengths of stay (day outliers) or extraordinarily high costs (cost outliers) compared with others classified in the same diagnosis-related group. Hospitals receive additional PPS payment for these cases.
Out-of-Network Provider	A doctor, nurse or other provider that is not in the health plan's network. Your health plan will usually not pay if you see these providers. Sometimes, you can see these providers, but you will have to pay for a greater part of the cost out of your own pocket.
Palliative Care	Also called "comfort care." Its focus is to improve quality of life through pain management and counseling for psychological, emotional, spiritual and physical distress. May include a curative course of treatment.
Partial Capitation	An insurance arrangement where the payment made to a health plan is a combination of a capitated premium and payment based on actual use of services; the proportions specified for these components determine the insurance risk faced by the plan.
Participating Physician and Supplier Program (PAR)	A program that provides financial and administrative incentives for physicians and suppliers to agree in advance to accept assignment on all Medicare claims for a one-year period.
Peer Review Organization (PRO)	A formal agency established to monitor the quality and appropriateness of medical care delivered to Medicare and Medicaid patients. Such organizations are made up of health care professionals who conduct reviews of other professionals with similar training and experience.
Personal Care	Bathing, grooming and transferring from chair to bed.
Personal Responsibility & Work Opportunity Reconciliation Act (PRWORA) of 1996	PRWORA eliminated the open-ended federal entitlement program of Aid to Families with Dependent Children and creates a new program called Temporary Assistance for Needy Families, which provides block grants for states to offer time-limited cash assistance. PRWORA also makes far-reaching changes to child care, the Food Stamp Program, Supplemental Security Income for children, benefits for legal immigrants, and the Child Support Enforcement program.
Physician/Hospital Organization (PHO)	An organization that contracts with payers on behalf of one or more hospitals and affiliated physicians. The PHO may also undertake utilization review, credentialing, and quality assurance. Physicians retain ownership of their own practices, maintain significant business outside the PHO, and typically continue in their traditional style of practice.
Point Of Service(POS) Plan	A managed-care plan that combines features of both prepaid and fee-for-service insurance Health plan enrollees decide whether to use network or non-network providers at the time care is needed and usually are charged sizable copayments for selecting the latter. Enrollees select providers either within or outside of a preferred network, with co-payment or deductibles higher for out-of-network providers. POS enrollees must receive authorization from a primary care physician in order to use network services.
Population at Risk	Segment of population with significant probability of having or developing a particular condition.
Portability	An individual changing jobs would be guaranteed coverage with the new employer, without a waiting period or having to meet additional deductible requirements. Insurers waive any preexisting condition exclusion for someone who was previously covered through other insurance as recently as 30 to 90 days earlier.
Post-natal Care	Health care services received by a woman immediately following the delivery of her child.
Preferred Provider	An arrangement whereby an insurer or managing entity contracts with a group of

Organization (PPO)	health care providers who furnish services at lower than usual fees in return for prompt payment and a certain volume of patients. Primary Care Provider (PCP) A healthcare professional who acts as a member's personal healthcare manager. The PCP evaluates a patient's medical condition and either treats the condition or coordinates required healthcare services.
Primary Care Case Management (PCCM)	A Medicaid managed care program in which an eligible individual may use services only with authorization from his or her assigned primary care provider. That provider is responsible for locating, coordinating, and monitoring all primary and other medical services for enrollees.
Primary Care Provider (PCP)	Health care professional capable of providing a wide variety of basic health services. Primary care providers include practitioners of family, general, or internal medicine; pediatricians and obstetricians; nurse practitioners; midwives; and physician's assistant in general or family practice. This doctor or health care provider will take care of most of the individual's health care needs. The PCP will decide when visits to other providers are necessary.
Prior Authorization (PA)	Authorization that certain specified services meet established criteria which is given before payment may occur.
Processed Claim	A claim that has been adjudicated, the remittance has been sent, and the claim has been properly paid or denied.
Professional Standards Review Organization (PSRO)	Organization, established in 1972, responsible for determining whether care and services provided were medically necessary and meet professional standards regarding eligibility for reimbursement under the Medicare and Medicaid programs.
Profiling	Expressing a pattern of practice as a rate - some measure of utilization (costs or services) or outcome (functional status, morbidity, or mortality) aggregated over time for a defined population of patients - to compare with other practice patterns. May be done for physician practices, health plans, or geographic areas.
Prospective Payment System (PPS)	Medicare system used to pay hospitals for inpatient hospital services; based on the DRG classification system. Prospective per-case payment rates are set at a level intended to cover operating costs in an efficient hospital for treating a typical inpatient in a given diagnosis-related group. Payments for each hospital are adjusted for differences in area wages, teaching activity, care to the poor, and other factors. Hospitals may also receive additional payments to cover extra costs associated with atypical patients (outliers) in each DRG.
Provider	A person, organization or institution that provides health care related services. Providers must be certified by DMS and enrolled in the Medicaid Provider program.
Provider Agreement	this means a contract between a provider and the office which sets out terms and conditions of a provider's participation in the Medicaid program, and must be signed by such provider prior to the payment of any reimbursement for providing covered services to Medicaid recipients.
Purchasing pool	Purchasing pools are organizations/groups that bring employers and consumers together to collectively purchase health coverage from health plans. By purchasing collectively, it is believed that administrative and other costs will be reduced.
Qualified Medicare income Beneficiary (QMB)	Individuals who are enrolled or receiving Medicare Part A benefits who have no greater than 100% of the Federal Poverty Level and resources no greater than twice the SSI limit. These individuals are eligible for payment of their Medicare premiums, deductibles, and coinsurance amounts by the Medicaid Program.
Quality Improvement) Organization (QIO	An organization contracting with HCFA to review the medical necessity and quality of care provided to Medicare beneficiaries. Previously, these were called Peer Review Organizations.
Rate Setting	A method of paying health care providers in which the Federal or state government establishes payment rates for all payers for various categories of health services.
Reinsurance	An insurance arrangement where an insurer pays a premium into a pool, and any claims paid by the insurer above a predefined dollar level are covered in whole or in part by the pool.

Relative Value Scale (RVS)	An index that assigns weights to each medical service: the weights represent the relative amount to be paid for each service. The RVS used in the development of the Medicare Fee Schedule consists of three cost components: physician work, practice expense, and malpractice expense.
Relative Value Unit (RVU)	The unit of measure for a relative value scale. RVUs must be multiplied by a dollar conversion factor to become payment amounts.
Remittance Advice	The statement mailed to a provider detailing the claim charges pending, paid, denied, or rejected.
Report Card	Any systematic presentation of information that assesses the performance of plans or providers, including consumer satisfaction, meeting certain standards, performance of certain processes, provision of certain services, or achieving medical outcomes.
Residential Care	Facility A facility which provides room and board, assistance with personal care and any necessary supervision.
Resource Based Relative Value Scale (RBRVS)	A government mandated relative value system implement January 1992 that is used for calculating national fee schedules for services provided to Medicare patients. Physicians are paid on relative value units (RVUs) for procedures and services. The three components of each established value are: work RVU, practice expense RVU, and malpractice expense RVU.
Respite Care	Temporary care given by another in place of the primary caregiver so the primary caregiver can take a break.
Reverse Mortgage	A loan against a person's home that requires no monthly payment. May be utilized by people with life-threatening illnesses to offset the possibility of losing their homes while in and out of hospitals or in costly treatment programs.
Risk Contract	An arrangement between a managed health care plan and HCFA under section 1876 of the Social Security Act. Under this contract, enrolled Medicare beneficiaries generally must use the plans' provider network. Capitation payments to plans are set at 95% of the AAPCC.
Risk Pools	Legislatively created programs that group together individuals who cannot get insurance in the private market. Funding for the pool is subsidized through assessments on insurers or through government revenues. Maximum rates are tied to the rest of the market. (AMA, 1993)
Risk-Adjusted Capitation	A method of payment to either an organization or individual period and which is varied to reflect the health characteristics of individuals or groups of individuals.
Safety Net	The health care safety net consists of inpatient and ambulatory health care providers that are legally obligated to provide care for those who cannot afford to pay for it. It includes public and private nonprofit hospitals (often teaching hospitals), public health departments, and community health clinics (CHCs), including federally qualified health centers (FQHCs).
Section 1115 Waivers	Section 1115 of the Social Security Act grants the Secretary of Health & Human Services broad authority to waive certain laws relating to Medicaid for the purpose of conducting pilot, experimental or demonstration projects which are "likely to promote the objectives" of the program. Section 1115 demonstration waivers allow states to change provisions of their Medicaid programs, including: eligibility requirements; the scope of services available; the freedom to choose a provider; a provider's choice to participate in a plan; the method of reimbursing providers; and the statewide application of the program. Demonstration waivers are granted for research purposes, to test a program improvement, or investigate an issue of interest to CMS. Projects must usually include a formal research or experimental methodology and provide for an independent evaluation. Most projects run for a limited time, no more than 5 years, and are usually not renewable.
Section 1902(r)(2)	Section 1902(r)(2) of the Social Security Act allows states to use other methods of counting income or assets for poverty-related pregnant women and children. Using this, some states greatly increase Medicaid eligibility by deciding not to count large portions of income. For example, even though the federal limit for younger children

	is 133 percent of poverty, a state could effectively increase the limit to 200 percent by not counting an amount equivalent to 67 percent of poverty.
Section 1915(b)	Section 1915(b) of the Social Security Act waivers allow states to require Medicaid recipients to enroll in HMOs or other managed care plans in an effort to control costs. These waivers allow states to: implement a primary care case-management system; require Medicaid recipients to choose from a number of competing health plans; provide additional benefits in exchange for savings resulting from recipients' use of cost-effective providers; and limit the providers from which beneficiaries can receive non-emergency treatment. The waivers are granted for two years, with two-year renewals. Section 1915(b) is often referred to as a "freedom-of-choice waiver".
Section 1931	Section 1931 of the Social Security Act was created by the 1996 federal welfare reform law which erased the connection between Medicaid and welfare. Section 1931 is related to the AFDC standards in use before the law's passage. Under Section 1931, states may modify methods of counting income and assets when judging Medicaid eligibility. Section 1931 offers states the ability to expand coverage of families, including parents. Section 1931 is also called the Family Coverage category.
Self-Insurance	Self-insurance is the practice of an employer, individual, or group of individuals assuming complete responsibility for losses which they could otherwise be insured against (such as health care expenses).
Single State Agency	The department of a state that is legally authorized and responsible for the statewide administration of the State's plan for medical assistance.
Skilled Nursing Facility (SNF)	An institution that has a transfer agreement with one or more hospitals, provides primarily inpatient skilled nursing care and rehabilitative services, and meets other specific certification requirements. Provides registered nursing services around the clock.
Small Group Market	The small group market is the insurance market for products sold to groups that are smaller than a specified size, typically employer groups with between 1 and 50 employees, or 2 and 50 employees. The size of groups depends on state insurance laws and thus varies from state to state.
Socialized Medicine	This phrase usually refers to health care system in which the doctors are paid by the government, and health care facilities are run by the government. In its broadest sense, it is government-run health care vs. market-based health care.
Special Services	Those medically necessary services, not otherwise covered by the Medicaid State Plan, which are available to children under age 21 and identified as necessary as the result of an EPSDT health screen.
Spenddown	Program which allows an individual who meets the technical requirements to be eligible for Medicaid but is over the income limit to qualify if the amount determined to be in excess during a specified period of time is obligated to cover medical expenses.
Standard Benefit Package	A defined set of benefits provided to all insureds or enrollees, which are usually outlined in health care reform proposals that are either government-run or market-based.
State Children's Health Insurance Program (SCHIP, Title XXI)	SCHIP is a federal program passed in 1997 through the Balanced Budget Act (BBA), jointly funded by states and the federal government. Title XXI was added to the Social Security Act, thus establishing a new state children's health insurance program. SCHIP provides funds to states at a higher matching rate than Medicaid to enable them to initiate and expand the provision of child health insurance to uninsured, low-income children who do not meet the Medicaid eligibility levels.
State Data Exchange (SDX)	A tape created by the Social Security Administration that contains all SSI eligibles and other data pertinent to each eligible, including termination dates, and changes to information on the record.
State Fiscal Year	The Commonwealth’s year for doing business, July 1 - June 30.
State Supplementation	The state funded cash assistance program for aged, blind, and disabled recipients who have sufficient income to meet special needs.

Subacute Care	Is usually described as a comprehensive inpatient program for those who have experienced a serious illness, injury or disease, but who don't require intensive hospital services. The range of services considered subacute can include infusion therapy, respiratory care, cardiac services, wound care, rehabilitation services, postoperative recovery programs for knee and hip replacements, and cancer, stroke, and AIDS care.
Supplemental Medical Insurance (SMI)	The part of the Medicare program that covers the costs of physicians' services, outpatient laboratory and X-ray tests, durable medical equipment, outpatient hospital care, and certain other services. This voluntary program requires payment of a monthly premium, which covers 25% of pro-ram costs. Beneficiaries are responsible for a deductible and coinsurance payments for most covered services. Also called Part B coverage or benefits.
Supplemental Security Income (SSI)	A federal income support pro-ram for low-income disabled, aged, and blind persons. Eligibility for the monthly cash payments is based on the individual's current status without regard to previous work or contributions.
Survey of Income and Program Participation (SIPP)	SIPP is a continuing survey, conducted by the Census Bureau, molded around a central core of labor force and income questions and supplemented with questions designed for specific topical needs. SIPP data may be used to examine policy issues such as the gain or loss of health insurance, welfare program participation, and the dynamics of health insurance coverage of children. SIPP will also be used to evaluate the effectiveness of HIPAA.
Sustainable Growth Rate	The target rate of expenditure growth set by the Sustainable Growth Rate system. Similar to the performance standard under the Volume Performance Standard system, except that the target depends on growth of gross domestic product instead of historical trends.
Swing-Bed Hospital	A hospital participating in the Medicare swing-bed program. This program allows rural hospitals with fewer than 100 beds to provide skilled post-acute care services in acute care beds. (HCFA)
Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)	Legislation that established target rate of increase limits on reimbursements for inpatient operating costs per Medicare discharge. A facility's target amount is derived from costs in a base year updated to the current year by the annual allowable rate of increase. Medicare payments for operating costs generally may not exceed the facility's target amount. These provisions still apply to hospitals and units excluded from PPS.
Temporary Assistance for Needy Families (TANF)	Temporary Assistance for Needy Families (TANF), the program most often referred to as welfare, provides cash assistance and work support for low-income families with children. TANF replaced the former Aid to Families with Dependent Children program (AFDC) as a result of changes under the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996.
Terminal Sedation	The continuous administration of medication which tranquilizes a person to unconsciousness, used at end stages of an illness to relieve pain until death.
Tertiary Center	A large medical care institution, usually a teaching hospital, that provides highly specialized care.
Third Party Administrator (TPA)	An organization that processes health care claims without bearing any insurance risk.
Third-Party Payer	An entity (private or public) that pays for or insures at least some of the health care expenses of its beneficiaries. Third-party payers include Blue Cross/Blue Shield, commercial health insurers, Medicare, and Medicaid. The individual receiving the health care services is the first party, and the individual or institution providing the service is the second party.
Title IV-E	Title of the Federal Social Security Act which authorizes financial assistance for foster children and for families receiving adoption assistance.
Title XIX State Plan	The comprehensive written commitment by a state Medicaid agency, submitted under section 1903 (a) of the Social Security Act, to administer or supervise the

	administration of a Medicaid Program in accordance with federal and state requirements.
Transitional Medicaid Assistance (TMA)	Transitional Medicaid was created by the 1988 Family Support Act (FSA), which required states to extend Medicaid coverage for up to 12 months to families who lost AFDC eligibility due to increased earnings. Under FSA, individuals could access TMA if they received welfare benefits and were eligible for Medicaid in at least three of the six months prior to the job. The PRWORA of 1996 extended the states' obligation to provide TMA through the year 2001. It provides for continuation of Medicaid benefits for families with increased earnings in excess of the July 1996 AFDC income and family composition standards as authorized in the statute. Eligible families are those who were receiving Medicaid benefits while receiving cash assistance under TANF based on those eligibility standards.
TRICARE (formerly CHAMPUS)	Insurance program for Veterans and civilian dependents of members of the military.
UB-92 (Unified Billing Form)	An updated version of UB-82, a uniform billing form required for submitting and processing claims for institutional providers. All services are billed in a standardized, consistent format on each invoice. It merges billing information with diagnostic codes, including almost all the elements from the uniform hospital discharge data set. The UB-92 is also referred to as the HCFA-1450 form.
Uncompensated Care	Care rendered by hospitals or other providers without payment from the patient or a government-sponsored or private insurance program. It includes both charity care, which is provided without the expectation of payment, and bad debts, for which the provider has made an unsuccessful effort to collect payment due from the patient.
Underinsured	The underinsured have public or private insurance policies that do not cover all necessary health care services, resulting in out-of-pocket expenses that exceed their ability to pay.
Uninsurables	Uninsurables are high-risk persons who do not have health care coverage through private insurance and who fall outside the parameters of the risks of standard health underwriting practices.
Uninsured	An uninsured person is one who, for various reasons (typically economic), is not covered by a health insurance contract to pay for medical expenses.
Universal access	The right and ability to receive a comprehensive, uniform, and affordable set of confidential, appropriate, and effective health services.
Usual, Customary, and Reasonable (UCR)	A method used by private insurers for paying physicians based on charges commonly used by physicians in a local community. Sometimes called customary, prevailing, and reasonable charges.
Utilization Review (UR)	The review of services delivered by a health care provider or supplier to determine whether those services were medically necessary; may be performed on a concurrent or retrospective basis.
Vertical Integration	A health care system that includes the entire range of health care services from out-patient to hospital and long-term care.
Viatical Settlement	The sale of an existing life insurance policy by a terminally ill person to a third party in return for immediate payment of a percentage of the face value of the policy. Often used to permit a person dealing with a life-threatening illness to transform a non-producing asset into immediate cash that can be used to improve the quality of his or her life.
Volume Performance Standard (VPS) System	The VPS system provides a mechanism to adjust fee updates for the Medicare Fee Schedule based on how annual increases in actual expenditures compare with previously determined performance standard rates of increase.
Waiver of Premium	Allows you to stop paying premiums while the policy is paying benefits.
Workplan	A comprehensive document which describes a task-by-task plan for completing major tasks.